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The Ethical Implications
of Differences in
the Availability of
Health Services

Volume Two: Appendices
Sociocultural and
Philosophical Studies



President's Commission for the Study of
Ethical Problems in Medicine and
Biomedical and Behavioral Research

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Securing Access to Health Care

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Philosophical Studies

March 1983

United States.

President's Commission for the Study of
Ethical Problems in Medicine and
Biomedical and Behavioral Research

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President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research

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Historical, Social, and Ethical Perspectives

I

Medical Care and the Pursuit of Equality in America



Paul Starr, Ph.D.*

After the Second World War, American society substantially reduced the gross disparities in access to medical care between the great mass of working-class families and the middle and upper classes. It also attenuated the regional inequalities in availability of services that had been particularly severe between the South and the rest of the country. These changes reflected more general historic processes: the absorption of the working class into a mass-consumption society and of the South in national economic development. But while "mass inequality" (as I will call the divergence of broad segments of the society from the consumption standard of the middle and upper classes) declined after the Second World War, there was an increase in the salience of what I will call "marginal inequality": the exclusion from access suffered by a smaller, but still significant number of poor Americans, who were "marginal" to the political system and the core industrial sectors of the economy.¹

In this shift from "mass" to "marginal" inequality in medical care, the rise of employee health benefit plans played a major role. Those who did not receive private health insurance as a fringe benefit either had to purchase it on much less favorable terms or were excluded altogether from coverage. And because private insurance had inflationary effects on medical costs, the rise of an employment-based system of financing

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September 1982

¹I am using "marginal" here in the sociological rather than the economic sense to describe the structure of social inequality rather than any measure of its overall extent. Though the term "marginal" may give rise to some misunderstanding, I have not been able to find any other that describes more accurately what I mean.

medical care may have actually made things worse for those, like the aged and the poor, who could not gain its protection. Neighborhood health centers, Medicare, and Medicaid were attempts to alleviate the problems of marginal inequality, which seemed unlikely to be solved by continued growth of the economy, the private insurance system, or the aggregate resources invested in medical care.

But neighborhood health centers, which showed the most promise of eliminating inequalities in access and improving the health of the poor, were sacrificed in appropriations to meet the budgetary appetite of the entitlement programs. The incentives Medicare and Medicaid offered for the expansion and intensification of services added to the imperatives toward growth already built into the private system of health insurance and inherent in the dynamics of scientific and technological change. The results are now all too familiar. Further growth in the share of national income devoted to medical care now seems out of the question economically, while further redistribution seems out of the question politically. Yet according to the most recent figures from the National Center for Health Statistics, over 26 million Americans still have no insurance protection, public or private.² Despite considerable progress in alleviating inequality since the 1960s, the basic economic and social forces that were aggravating the problems of the marginal poor have not been overcome. With real incomes falling, these problems are likely to get worse. So now seems not just an opportune moment, but a necessary one, to reexamine what sort of equality we have been aiming to achieve in medical care, by what means, at what standard, and with what effects.

The Changing Meaning of Equality

In *DEMOCRACY IN AMERICA*, written in the 1830s, de Tocqueville observes that Americans have a passion for health and well-being as well as for equality.³ But nowhere does he mention any passion for equality of medical care. At the time he wrote, the care of the sick was still mainly the function of the family, supplemented by an array of practitioners only some of whom were trained physicians. Though we have no exact data, we can be sure that rich and poor received different sorts of care when they were sick. Indeed, unlike the relatively homogeneous profession that physicians constitute today, the practitioners of the nineteenth century were extraordinarily heterogeneous in training and therapeutic orientation. They were probably as diverse in social status as their communities were

²U.S. Department of Health and Human Services, National Center for Health Services Research, *Who are the Uninsured?* DATA PREVIEW 1 (1980). The figures are for 1977-78.

³Alexis de Tocqueville, *DEMOCRACY IN AMERICA*, tr. Henry Reeve (New York: Schocken Books, 1961), v. 2, pp. 153-58.

stratified. Educated physicians who had been trained in Europe or in the better medical schools of Eastern cities practiced among the higher grades of society, while in rural areas and among the poor, medical care was in the hands of the older women, self-taught empirics, and doctors with no more than an apprenticeship or a term at a provincial medical college. Yet however unequal the availability of physicians undoubtedly was, unequal access to their services was not a political issue. Quite the opposite: The demand heard from radical movements of the early nineteenth century was for medical liberty, not equality—for equality in rights to practice, rather than in rights to service. The advocates of botanic medicine and home remedies wanted no privileged position given to educated physicians through licensing laws, but rather the freedom for anyone to practice healing regardless of training or method. And just as they did not insist on a wider availability of physicians, still less did they seek wider access to hospital care, since the very existence of hospitals was considered a misfortune, necessary only for the poor and those without families to care for them. Progress, it was hoped, would bring the abolition of hospitals, not their extension.

So equal access to medical and hospital care is not an ideal, like equality before the law, that comes to us from the founding of the republic. It originated later, and it is only one of several forms that the pursuit of equality may take in medical care.

At least three conceptions of equality seem to have been particularly important in medical care in American history, each corresponding to a different period of social development. The first ideal, equal rights to practice, which also included easier popular access to medical knowledge by eliminating obscurity and mystification, belongs to an era of economic individualism and self-reliance. The appeal of the phrase “every man his own doctor” stemmed partly from the demands of a largely rural society where people on isolated farms or in small villages had to care for themselves, and partly from a belief in the adequacy of common sense and a suspicion that any claim of the learned professions to special skill was an attempt to justify privilege.

The shift in political thought (and eventually, public policy) to an emphasis on equal access to services began only in the late nineteenth and early twentieth centuries, as Americans accepted professional claims of special competence and enacted laws regulating medical practice. Only when a consensus emerged about the superior effectiveness of scientific medicine did the earlier *differences* in medical care loom as *inequalities*. And, once again, this went along with an entire way of life and distinctive culture, as the faith in common sense and self-reliance gave way to the authority of science and the professions.

More recently, the ideal of equality in medical care has taken on yet another meaning: equal rights to participation—in both one's individual treatment and the control of medical institutions. Although this has by no means replaced a concern for equal access to services (in fact, it seems to emerge from this concern), it reflects another concern—that professionals have frequently overstepped the legitimate boundaries of their authority. And as a new meaning for equality in medical care, it belongs to an age of widely shared grievances against professionalism and bureaucracy.

My concern here is primarily with the second meaning—equal access to medical services. But even that conception has considerable ambiguity and has changed over time. The relatively narrow set of services that physicians and hospitals performed at the turn of the century has expanded into an immense variety that come underneath the rubric “health care” today. Whether equal access ought to involve all these services is uncertain; law as well as opinion has varied as to what services qualify as legitimate “medical needs.” Moreover, if there is a right of access to such services, against which institutions (government, hospitals, etc.) can obligations to satisfy those rights be enforced? Here too there has been change. And, finally, if some specific institutions have obligations of this kind, what do those obligations entail? To guarantee equal access, is it enough *not to discriminate* in providing services with whatever resources are available? Or must resources be made *equally available*, and if equally available, must *equal means of access* to them (money, transportation, time) be provided? And if some people have insufficient knowledge to recognize their own needs, or to choose among potential sources of care, is there an obligation to provide better information to make the capacity for access more equal?

On these questions there has been a range of views. If equal access to medical care is the product of at least four variables—(1) the availability of facilities, (2) the possession of the means of access, (3) nonexclusionary attitudes and conduct of professionals and institutions, and (4) various forms of individual competence, such as the capacity to recognize one's own medical needs—then one can construct a kind of “scale of actions” that equality of access might entail. On this scale, a key dividing point comes between the first pair, both of which involve resources, and the second pair, both of which involve behavior.

In the early twentieth century, the debate over equal access had what now seems like a great simplicity, because the range of medical services was smaller, there appeared to be little ambiguity about “unmet needs,” and the barriers to access seemed to be primarily economic. In other words, resources seemed to be the entire issue. And, although never completely

true, this was more the case with the industrial working class than with the marginal poor. As political concern has shifted to the marginal poor, the second pair of variables—those involving discrimination and differences in response to illness—have become increasingly conspicuous as barriers to access. Many have argued that adding resources is not enough and that the special problems of the poor, especially minorities, require more thoroughgoing changes in organization and behavior. In this sense, the problems of the poor have posed a more serious challenge to the structure of medical care and the boundaries of social policy than did the earlier difficulties of working families.

Availability, access, and use are three different things. To make some service equally available is not necessarily to provide equal access, and to provide equal access is not to guarantee equal use when needed. Even where our society makes some kind of commitment to equality, it does not necessarily commit itself to equalize all three. In 1972, Franz Ingelfinger, the late editor of the *NEW ENGLAND JOURNAL OF MEDICINE*, wrote that “any person within the United States has as much right to health care as he does to adequate transportation, postal service, and fire protection.”⁴ The comparison is inexact, but suggestive. The right to postal service is a right of availability, not of access: The government guarantees to transmit mail in and out of communities, but not that you will have enough money to send letters. Insofar as there is a right of access to the U.S. mail, it is a right of communities rather than individuals. (The government does, however, guarantee to deliver your mail if somebody else has paid the postage.) On the other hand, local government typically provides fire protection regardless of your ability to pay, in part because of the risk to others. Some aspects of medical care, such as the control of contagious diseases, have long been considered like fire protection; providing access to those who cannot afford services has been understood as a matter of community welfare. Other aspects of medical care have been treated more like the postal service: Government has been willing to acknowledge a right of availability, but not necessarily of access. (This seems to have been the premise of the Hill-Burton hospital construction program.) And some aspects of medical care have been treated as matters of individual consumption that entail no obligations of the community. The historical problem—or least part of it—is to explain the decline of this latter category and the rise of demands not just for equal availability, but also for equal access and equal results.

⁴ *THE WALL STREET JOURNAL*, March 27, 1982, p. 8.

Origins of Unequal Access as a Political Problem

As I've already suggested, equity and efficacy have a direct historical connection. The variations in medical care among different classes became widely perceived as inequalities only as a consensus developed that scientific medicine was effective. But there is a further point: Paradoxically, the growing consensus at the turn of this century about the value of scientific medicine had the effects of both restricting access to medical care and granting that it was absolutely necessary for health.

Although the consensus about the value of professional treatment in sickness was far from universal, it was sufficiently strong by the 1870s and 1880s to enable physicians to begin securing the enactment of medical licensing laws. The requirements in these laws, however, were initially quite minimal. They were only gradually increased, and probably not until the 1920s were they widely enforced. In that same period, as licensing laws increased the required length and expense of training, the number of medical schools and medical school graduates declined sharply. The demise of small medical colleges was also hastened by the famous report of Abraham Flexner to the Carnegie Foundation in 1910, which argued that the best interests of the society lay in producing "fewer but better" doctors. Eliminating alternative practitioners and restricting the number of physicians also had the effects, however, of freeing doctors from competition, increasing their incomes, and making them less willing to locate in poor communities.

In adopting a restrictive policy toward medical practice, government had, in effect, begun redistributing medical services—though not in the interests of equal access. For the state had told many people who could not afford the services of an educated physician, "You may not receive care from any other kind of practitioner." In the nineteenth century, practitioners with different degrees of training were available at all levels of the community, but by the early twentieth century only educated and necessarily more expensive doctors were allowed to practice. What was formerly a continuum of practitioners in training and price now became a sharply discontinuous distribution. The restrictive policy increased medical costs and barriers to access for the segments of the society that previously relied on practitioners with less formal training. In this sense, public policy magnified problems that already existed because of differences in income.

In other ways, government and nonprofit institutions provided medical aid to the poor. The late nineteenth century saw the spread of hospitals and dispensaries for the poor, mainly in the larger cities of the East. But the animating ideal was charity rather than equality. The poor who received these services were

definitely not being provided them as a matter of right. There was no systematic attempt to assure that those who might need medical care received it, except perhaps in the case of epidemic diseases that threatened the community. The chief political issue, in fact, was the control of what was called "hospital and dispensary abuse," the equivalent of today's "welfare chiseling." Private practitioners worried that overzealous donors, medical schools in need of patients for educational purposes, and struggling young physicians eager for entry into the community would combine to deprive them of patients who could well afford to pay for private care. For much the same reasons, the profession resisted the extension of public health agencies into medical service. Like many other small businessmen, doctors feared that subsidized competition by government or charities would drive down their incomes, and so they organized to defend their claim on the market. Government generally respected this claim. The result has been a pervasive division throughout the entire medical system between the medical care provided to poor people and to other people.

In the early twentieth century, the basic premises of charity came under attack as a vestige of paternalism. Progressive reformers sought to replace charity with a system of compulsory insurance that provided medical care and sick pay as a right in return for contributions to an insurance fund. The Progressives argued that increasing access to medical care by industrial workers would improve their productive efficiency and generally aid "the conservation of human resources," seen as analogous to the conservation of natural resources. It was partly on this basis that a presidential commission on industrial relations, established by Woodrow Wilson, called for the adoption of compulsory health insurance in 1916.⁵ Skepticism about the value of medicine, wrote the prominent reformer I.M. Rubinow, may have made sense a half century ago, but now "No reasonable being will doubt the tremendous efficiency of competent medical aid."⁶ After reviewing the evidence that from one-fourth to two-fifths of the sick were not receiving medical assistance, a state commission in Ohio observed in 1918, "All the facts point to the conclusion that we need a democratization of medical service."⁷ Democratization here clearly meant wider

⁵Commission on Industrial Relations, FINAL REPORT AND TESTIMONY, U.S. Senate Doc. 415, 64th Cong., 1st sess. (1916), vol. 1, pp. 124-27.

⁶I.M. Rubinow, SOCIAL INSURANCE (Chicago: American Medical Association, 1916), p. 24. Rubinow, a socialist, had been hired by the American Medical Association (AMA) to direct its study of health insurance at a time it was sympathetic to the idea. At 1916 congressional hearings, he represented both the AMA and the Socialist Party—undoubtedly the only time in history anyone has served in those two capacities at the same time.

⁷Ohio Health and Old Age Insurance Commission, HEALTH, HEALTH INSURANCE, OLD AGE PENSIONS (Columbus, Feb. 1919), p. 136.

access to professional health services, rather than a right of all to practice healing (as it would have meant a century earlier) or a right of all to participation (as it might mean today).

The defeat of insurance proposals during the Progressive Era and the New Deal not only delayed the development of health insurance in America until it emerged on a private and voluntary basis, it also guaranteed that the financing of medical care for the poor would be separate from financing of other people's medical services. While a general program of health insurance was defeated in the 1930s and 1940s, public assistance payments for medical care increased at the local and state levels. Beginning around 1930, states and localities, particularly in the more industrialized regions of the country, began recognizing medical care as an "essential relief need." Federal support for locally run welfare medical services quietly expanded over the next three decades, well before Medicaid. In the same period, a system of private health insurance emerged first to cover middle-income subscribers and then, after the Second World War, encompassing unionized and other well-paid workers. So instead of a "universalistic" system of health insurance that would have financed medical care for all classes of society out of the same fund, we developed separate financing arrangements that segregated the poor from both the working and middle classes.

The Widening of Inequality, 1870-1940

Regional inequalities in the availability of physicians began increasing even before the Flexner report. Between 1870 and 1910, the poorer states generally lost physicians relative to population, while the wealthier states gained them. For example, in 1870 for every 894 persons in South Carolina there was one doctor, compared with 712 persons per doctor in Massachusetts (an excess of about 25%). By 1910, the number of people per doctor had risen to 1170 in South Carolina and fallen in Massachusetts to 497 (an excess of 135%).⁸ The same pattern was evident in the disparities between cities and rural areas. During the same 40-year period, the number of physicians per 100,000 population increased from 177 to 241 in the large cities, while it fell from 160 to 152 in the rest of the country.⁹

After 1910, as the number of medical graduates declined, the shifts continued. The output of physicians did not keep pace with the population as a whole. Between 1910 and 1930,

⁸American Medical Association, Committee on Social Insurance, *STATISTICS REGARDING THE MEDICAL PROFESSION* (Chicago: American Medical Association, 1916), pp. 38-39.

⁹*Ibid.*

the ratio of doctors to population fell from 164 to 125 per 100,000.¹⁰ The drop was even steeper in rural areas, as physicians migrated to cities and new graduates chose not to locate in small towns. In 1906, small towns (population 1000-2500) had 590 people per doctor, while large cities (population over 100,000) had 492. By 1923, the small towns had 910 people per doctor, the large cities, 536: The small towns' deficit had grown from about 20 to 70%.¹¹ As a study by the General Education Board pointed out, while the overall decline had reduced the number of physicians in the cities, it meant "the complete abandonment" by doctors of communities that had been accustomed for years to look to them for medical care. By the 1920s, there was widespread talk of the "vanishing country doctor."¹² A study by the AMA of physicians' choices in locating their practices found that the distribution was closely correlated with per capita income. Doctors, the report concluded, behaved the way all "sensible people" do. "They do business where business is good and avoid places where it is bad."¹³

And things got worse. Comparisons of high- and low-income counties and high- and low-income states in the 1920s and 1930s both show a widening gap. Between 1923 and 1938 the number of physicians in the poorest counties fell from 74 to 54 per 100,000 people, while in the wealthiest the number rose from 159 to 176 per 100,000 people. In other words, the wealthy counties, which were twice as well off in physicians in 1923, were three times as well off by 1938.¹⁴ The ratio of high- to low-income states in physicians per capita, which was 1.7 in 1930, rose to 2.1 in 1940.¹⁵

Hospital facilities were also distributed in a highly unequal way during this period. The Northeastern and Middle Atlantic states had nearly twice as many hospital beds per person as the Southern states. The level of investment per bed was also

¹⁰U.S. Bureau of the Census, *HISTORICAL STATISTICS OF THE UNITED STATES, COLONIAL TIMES TO THE PRESENT* (Washington, DC: G.P.O., 1975), p. 76.

¹¹Lewis Mayers and Leonard V. Harrison, *THE DISTRIBUTION OF PHYSICIANS IN THE UNITED STATES* (New York: General Education Board, 1924), pp. 47-48.

¹²Samuel Hopkins Adams, *The Vanishing Country Doctor*, with sequels, *LADIES' HOME JOURNAL* 40 (Oct. 1923), pp. 23ff; (Nov. 1923), pp. 26ff; 41 (Feb. 1924), pp. 31ff.

¹³Raymond Pearl, *Distribution of Physicians in the U.S.*, *JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION* (April 4, 1925), pp. 1024-27.

¹⁴Joseph W. Mountin et al. *Location and Movement of Physicians, 1923 and 1938: General Observations*, *PUBLIC HEALTH REPORTS* 57 (Sept. 11, 1942), pp. 1363-75; *idem*, *Location and Movement of Physicians, 1923 and 1938: Effect of Local Factors Upon Location*, *ibid.*, pp. 1945-53.

¹⁵Monroe Lerner and Odin W. Anderson, *HEALTH PROGRESS IN THE UNITED STATES 1900-1960* (Chicago: University of Chicago Press, 1963), p. 124.

higher: Capital investment in hospitals per person was four times as high in the North as in the South, while the other regions were close to the national average.¹⁶

Access to medical care also depends on the distribution of the means of access—telephones, automobiles or public transportation, and money or insurance coverage. And, in these respects as well, through the Depression there were severe differences between rich and poor, and between rich and poor areas of the country. Again, rural areas and the South were at a severe disadvantage. In 1920, when about 30% of the farms in the country had automobiles, the proportions ranged from 60% in some Northern states to as low as 6% in some Southern states. In the North, the proportion of farms with telephones in 1920 was as high as 86% in Iowa and averaged over 50%, while in the South it ranged from 18% in Virginia to 6% in South Carolina and Louisiana.¹⁷ Per capita income in the Southeast was 49.9% of the national average in 1880 and still only 50.2% in 1930.¹⁸ All these factors—automobiles, telephones, income—were, of course, only symptoms of overall variations in economic development.

Not surprisingly, these variations in availability and access to medical care produced great disparities in the receipt of medical services. The Committee on the Costs of Medical Care (CCMC), a foundation-sponsored commission established in 1927, found a strong direct relation between family income and use of physicians' services. Among people in families with less than \$1200 in income a year, 46.6% had not received any medical, dental, or eye care in the previous year, compared with only 13.8% among those in families with \$10,000 or more in annual income. In the low-income category, 33.5% of illnesses received no medical attention, compared with 7.3% in the high-income group.¹⁹

Especially striking is the relative similarity in the rates of use among the entire lower half of the income distribution. Families with annual incomes of less than \$1200 (15% of the sample of 8639 families) averaged 2169 physician calls per 1000 persons. The number of calls rose to only 2269—an increase of only 5%—in the next income category, families with \$1200-\$1999 (35% of the total). Indeed, the curve was relatively flat until it reached the top quarter of the income distribution (incomes over \$3000) and it climbed sharply within that group.

¹⁶C. Rufus Rorem, *THE PUBLIC'S INVESTMENT IN HOSPITALS* (Chicago: University of Chicago Press, 1930), p. 49.

¹⁷Mayers and Harrison, *DISTRIBUTION OF PHYSICIANS*, pp. 80-82.

¹⁸Harvey S. Perloff et al., *REGIONS, RESOURCES AND ECONOMIC GROWTH* (Lincoln: University of Nebraska Press, 1960), p. 27.

¹⁹I.S. Falk et al., *THE INCIDENCE OF ILLNESS AND THE RECEIPT AND COSTS OF MEDICAL CARE AMONG REPRESENTATIVE FAMILIES* (Chicago: University of Chicago Press, 1932), pp. 103, 281.

The rate of physician visits among families with \$10,000 income or more (3.3% of the total) was 5321 per 1000 persons—or more than twice as high as the rate among the poorer half of the society.²⁰

This sharp difference in access to medical care between the broad bottom and the top of the social structure, as well as the gap in the availability of services between the South and the rest of the country, is what I mean by “mass inequality.” Although the evidence suggests the pattern preceded the 1930s, the Depression unquestionably made it worse. A study of families in ten working-class communities, covering the years 1929 to 1933, showed that those whose incomes dropped from “comfortable” to “poor” severely curtailed their use of physicians’ services, though their rates of sickness and hospitalization increased.²¹

From Mass to Marginal Inequality

Undoubtedly the major factor that began to improve access to medical care among working families and in the South was the overall growth in income beginning in the 1940s, which made possible a vast expansion of medical resources and private health insurance. Some improvement in access also resulted indirectly from urbanization. And public policy, via the Hill-Burton program, had a redistributive impact on the availability of hospital facilities.

Economic growth after the Depression steadily reduced differences in per capita income and medical resources among regions and between high- and low-income states. Between 1940 and 1957, per capita income in the South rose from 57.6 to 70.4% of the national average.²² Between 1950 and 1970, per capita income was up 63.7% nationally, but by 88.2% in the lowest third of the states and by only 53.2% in the highest third. Hospital beds per 1000 persons increased 24% nationally, but by 44.5% in the third of the states with the lowest levels of supply and by only 13.3% in the third of the states with the greatest supply. Less impressively, the ratio of physicians to

²⁰*Ibid.*, p. 283. Unfortunately, the CCMC study did not include blacks or provide separate data on the South. Rates of physician visits were approximately 30% lower in small town and rural areas than in big cities; since the low-income families were concentrated in those areas, some of the socioeconomic difference can be explained by location of residence. As will be evident, the increasing use of medical services by the poor is partly a result of their urbanization.

²¹G. St. J. Perrot, Edgar Sydenstricker, and Selwyn D. Collins, *Medical Care During the Depression*, MILBANK MEMORIAL FUND QUARTERLY 12 (April 1934), pp. 99-114.

²²Perloff et al., *REGIONS, RESOURCES AND ECONOMIC GROWTH*, p. 27.

population grew 11.2% nationally, but by 18.7% in the states with fewest physicians and by 8.2% in the states with most physicians. (This growth came entirely in the 1960s; in the previous decade, ratios of doctors to population had continued to fall.) By 1970, there was no longer any significant deficit in hospital facilities in the poorer states, though they continued to show much lower rates of physicians. In large measure, the state-by-state equalization in the availability of hospital facilities was the achievement of the Hill-Burton hospital construction program, enacted in 1946. Some of the original sponsors of the program had hoped it would also improve the distribution of physicians, on the theory that doctors would be more willing to locate in underserved regions if they had access to modern hospitals. The evidence indicates, however, that the theory was wrong: Hill-Burton did not have any positive effect on the distribution of physicians.²³

With the spread of health insurance, working-class families pulled closer to the middle class in means of access to medical and hospital care. In 1940, only one of ten people in the United States had any form of health insurance. By 1945, the proportion had reached one in five. It then jumped to better than six in ten by 1953 and better than seven in ten a decade later. Early surveys in the forties indicated that the subscribers were predominantly middle income, but as insurance became more widespread and unions gained the right to bargain collectively for health benefits, the distribution shifted. The major surge in negotiated health plans occurred between 1948 and 1950, when collective bargaining agreements in the leading manufacturing industries included health insurance plans.²⁴ By 1953, 71% of families with incomes between \$4000 and \$7000 a year had some insurance, compared to 80% among those with more income and 41% among those with less.²⁵

Postwar data on the use of medical services indicate diminishing socioeconomic differences, but the evidence needs to be interpreted carefully. High use of medical services by low-income persons is partly to be expected, because a high proportion of low-income persons are old, and many are poor because they are disabled. Hence high rates of use may not indicate greater access, only greater need. However, an index of access may be constructed indirectly by adjusting the data on so-

²³Lawrence J. Clark et al., *The Impact of Hill-Burton: An Analysis of Hospital Bed and Physician Distribution in the United States, 1950-1970*, MEDICAL CARE 18 (May 1980), pp. 532-550.

²⁴See Joseph W. Garbarino, *HEALTH PLANS AND COLLECTIVE BARGAINING* (Berkeley: University of California Press, 1960).

²⁵Ronald Andersen and Odin W. Anderson, *A DECADE OF HEALTH SERVICES: SOCIAL SURVEY TRENDS IN USE AND EXPENDITURE* (Chicago: University of Chicago Press, 1967), pp. 76-77.

cioeconomic differences in the use of medical services according to some measure of disability or ill health. Another approach is to consider only the rates of medical care among children, whose illnesses are less likely to affect family income than are those of adults. Using either approach for data from the 1950s and 1960s, the expected socioeconomic differences reappear. Higher-income families continued to enjoy substantially greater access. For example, in the 1963-64 National Health Survey, physician visits per child under five years of age increased from 3.1 annually in families with incomes under \$2000 to 7.5 in families with incomes over \$10,000. But in contrast to the CCMC findings in 1928-31, the pattern was no longer a low, flat curve among the lower half of the income distribution with rapid increases among the top quarter. On the contrary, the rates now tended to climb quickly as one moved along the curve and to flatten out for the upper half. This is the pattern of marginal inequality.

Especially striking are the racial differences. Data from 1958-59 indicate that whites were seeing physicians 50% more often than nonwhites.²⁶ Only 46% of nonwhites had hospital insurance in 1962-63, compared with 74% of whites.²⁷ In the South there was open discrimination against blacks in hospital facilities. In Atlanta, as late as 1963, blacks had access to 630 hospital beds out of 2500, although blacks then constituted about 50% of the population.²⁸ White physicians segregated blacks in separate waiting rooms and often only agreed to see them once their white patients had been treated.

The problems of minorities, the poor, and the aged were in some ways exacerbated by the private insurance system, which left them out not necessarily because of discrimination, but because of their location in the economy. Private insurance was based primarily on employment. Channeling insurance through employment greatly reduced the risks of adverse selection faced by voluntary health plans, and it cut their administrative expenses by simplifying acquisition of business and the collection of premiums. People who had to buy insurance individually had to pay more for the same coverage than those who received it as a fringe benefit. While Blue Cross retained about 7% of income for administrative expenses in group insurance, it retained 22% on individual policies. This was still much less than the about 50% retained by commercial insur-

²⁶U.S. Department of Health, Education and Welfare, National Center for Health Statistics, *Volume of Physician Visits, by Place of Visit and Type of Service, United States, July 1963-June 1964*, Series 10, Number 18, p. 13.

²⁷*Idem*, *Health Insurance Coverage . . .*, Series 10, Number 11, p. 14.

²⁸Max Seham, *BLACKS AND AMERICAN MEDICAL CARE* (Minneapolis: University of Minnesota Press, 1973), pp. 15-16.

ers.²⁹ And, of course, because the companies competed partly by seeking the best risks, they avoided altogether many of the unemployed, the aged, the disabled, and the poor.

Private insurance also had regressive effects because of its pricing practices. Instead of the sliding scale charged by private physicians and hospitals, Blue Cross originally charged the same rate for all income levels. Charging uniform rates increased the costs of low-income families and reduced those of high-income families relative to the previous distribution of costs under the sliding scale.

The only estimate of the distributive impact of voluntary insurance that I have been able to find comes from an obscure report of a 1946 New York State legislative commission. The commission tried to determine how much of their income different families would have to pay to receive the same level of medical service as families earning \$5000 or more a year. First, it assumed that families would continue to pay for services according to the graded fees currently charged them. In that event, families earning under \$1000 a year would have to spend 7.5% of their income to get "full" service instead of the 4.1% they currently spent on medical care. Families with \$5000 or more annual income would continue to spend 2.0% of theirs.

The commission then assumed that the families would receive full service on an insurance basis, with the same premium being charged regardless of income. In that event, families earning less than \$1000 would have to spend 15.7% of their income, while families with \$5000 or more income would have to spend only 1.0%. In general, insurance began reducing the proportion of income spent on health care once income exceeded \$2500. As the commission wrote, "Insurance presents a distinct financial advantage to those earning more than \$2500 per year, since they can obtain adequate care at less than the average cost which they are accustomed to pay. For the lower income groups, the percentage of family income required is so great as to be prohibitive."³⁰

Commercial insurance companies, however, operated on a still more regressive basis than Blue Cross and Blue Shield. They rated every employee group according to its "experience." A young, relatively healthy group received a reduced rate because its costs were likely to be low. By the same token, an older, relatively unhealthy group had to pay more because its costs were likely to be high. The commercial insurers maintained that a "community" rate that charged everyone the same was inequitable because it cost healthy people too much—that

²⁹Herman N. and Anne R. Somers, *DOCTORS, PATIENTS AND HEALTH INSURANCE* (Washington, DC: Brookings, 1961).

³⁰New York State Legislative Commission on Medical Care, *MEDICAL CARE FOR THE PEOPLE OF NEW YORK STATE* (Feb. 1946).

is, more than they would have to pay for insurance in a competitive market. Experience rating allowed the commercial insurers to undersell the Blues in competing for low-risk groups, and eventually the Blues had to yield to the logic of competition. As the commercial insurers in the forties and early fifties began to pick off low-risk employee groups, they threatened to leave the high-cost population to the Blues. Had this process continued indefinitely, Blue Cross and Blue Shield would have been forced to raise their rates to the point that even average-risk groups would have found it cheaper to buy commercial insurance. Eventually, the Blue plans would have become "dumping grounds" for the aged and the poor. This, however, was a role they preferred to leave to the government; and so, despite some reluctance, they too moved toward experience rating, which meant higher costs for groups that had more workers who were poor or old or chronically ill.

Despite the highly unequal distribution of private health insurance, the Federal government subsidized it indirectly through the tax system. The Internal Revenue Code of 1954 confirmed that employers' contributions to health benefit plans were tax-exempt—an exemption that constituted a massive subsidy to those who received private insurance as a fringe benefit of employment. The higher their tax bracket, the greater the subsidy to their insurance. Though hardly visible, this policy—which today represents the second largest Federal expenditure on medical care—was one way in which government actually contributed to inequality in access to medical care.

The Attack on Marginal Inequality, 1965-1980

The rediscovery of poverty in the 1960s and the triumph of the liberal agenda in the aftermath of the Johnson landslide gave rise to a new generation of social programs to deal with the health problems of the poor. These new programs reflected a general shift of emphasis in American social policy from growth to redistribution, but they had significantly different historical origins.

Medicare developed out of the social insurance tradition and became rapidly integrated into Social Security as a highly legitimate government program. Medicaid, on the other hand, was a continuation of the public assistance tradition and was never granted equal legitimacy by the press and the public. However, like Medicare, it was also an "entitlement" program that, once enacted, developed a momentum of its own. A variety of smaller efforts, such as rural health programs and the National Health Service Corps, evolved out of the programs to aid medical education and increase medical resources that had been established over the previous two decades. As these programs were now used for purposes of redistribution as well as

growth, they also introduced a dose of the “new social regulation” (for example, to medical schools). Finally, neighborhood health centers represented still another model for achieving equal access to health care, based on public rather than private services and on community participation rather than professional control and autonomy. Some health centers, especially in their early years, challenged the traditional barriers between medical care and public health and the usual hierarchical relations among physicians, other health workers, and consumers.

So, in a sense, these new programs were located at different points on the scale of action for the pursuit of equal access that I mentioned earlier. The medical resource and regulatory programs were concerned with improving the availability of services. Medicare and Medicaid were concerned primarily with amplifying the means of access (i.e., purchasing power), though Medicare also included provisions barring discrimination. Neighborhood health centers, in addition to providing new resources in poverty areas, had more thoroughgoing aims in altering the behavior of those who served the poor, raising the competence of the poor themselves in maintaining their own health, and cultivating indigenous leadership of community health services.

Medical care for the poor was not initially a central issue of the war on poverty. The chief objective of liberal reform in health care was originally Medicare. Ever since being stung by defeat in the Truman years, the advocates of compulsory health insurance had retreated to a hospital insurance program for the aged. Medicare's appeal lay for the middle class as much as for low-income people. Medicaid was tacked on by Wilbur Mills almost as an afterthought and was considered of secondary importance at the time the two programs were enacted. The provisions of Medicaid that later resulted in the huge growth of nursing homes were written without any anticipation of their effects on medical services and expenditures. The original Office of Economic Opportunity (OEO) legislation included no provisions for medical care; the authorization for neighborhood health centers was added in amendments in 1966. However, in plans developed by HEW in 1967, the administration looked mainly to health centers rather than to Medicaid as the main vehicle for providing medical care to poverty areas. Plans called for 1000 centers serving 25 million people by 1973. This program, of course, was never carried out—and yet not because neighborhood health centers were any less successful than other alternatives. Policy-makers did not deliberately and strategically choose Medicaid over neighborhood health centers on the basis of any evaluation of their cost effectiveness. Medicaid simply had the advantage of institutional compatibility and nondiscretionary funding (insofar as minimum eligibility levels were federally required): It raised no challenge to private inter-

ests in the medical sector. In terminology I have used elsewhere, it was a form of "passive intervention"—that is, a kind of government intervention that accommodates and subsidizes the existing pattern of private interests. Neighborhood health centers were a much more "active" and threatening form of intervention whose development was arrested more by political opposition than by any failure to achieve its goals.

The decade after 1965 witnessed an extraordinary increase in the use of medical services by the poor. In 1964, the nonpoor saw physicians about 20% more frequently than the poor; by 1975, the poor visited physicians 18% more often. In 1964, whites saw physicians 42% more often than blacks; by 1973, whites still saw physicians more often, but only by 13%. In 1963, those with incomes under \$2000 a year had only half as many surgical procedures per 100 people as those with incomes of \$7500 or more, but by 1970 the rate for the low-income group was 40% higher.³¹

On numerous other indices, the use of medical care by the poor has increased. Undoubtedly most of this increase is due to the increased access that Medicare, Medicaid, and other programs have created. Thus Davis and Reynolds, using data from 1969, show that for every level of health status, public assistance recipients use medical services more than other low-income people. A recipient with average health would see a physician 50% more often than another poor person (with average health) not eligible for Medicaid.³²

Another reason for the increased use of medical care by the poor—which seems to have gone virtually unnoticed in research in this area—is that the composition of the poverty population has been steadily changing in America over the last half-century. When the Committee on the Costs of Medical Care did its studies in 1928-31, the poor were not a measurably sicker population.³³ The reasons are evident when one considers who used to be poor in America. Low income was predominantly rural and Southern and, particularly during the Depression, a function of unemployment. Since the Second World War, the sources of poverty have been changing. Rural-urban and regional differences have been of diminishing importance

³¹Karen Davis and Cathy Schoen, *HEALTH AND THE WAR ON POVERTY: A TEN YEAR APPRAISAL* (Washington, DC: Brookings, 1978), pp. 41-48.

³²Karen Davis and Roger Reynolds, *The Impact of Medicare and Medicaid on Access to Medical Care*, in Roger N. Rosett, ed., *THE ROLE OF HEALTH INSURANCE IN THE HEALTH SERVICES SECTOR* (New York: National Bureau of Economic Research, 1976).

³³In fact, the CCMC data indicate—probably as a result of measurement error—that rates of illness increased with income. Other studies from the period show the opposite pattern. However, the relation between poverty and ill health is weaker than in subsequent studies.

in the distribution of income. An increasing proportion of the poor are poor because the head of household cannot work.³⁴ Luft has shown that about 65% of poor families consisting of at least a husband and wife include a disabled adult, and at least 30% of the disabled who are currently poor are poor because of their health problems. Among white men, he suggests, the proportion is near 75%.³⁵ Unfortunately, we do not have any reliable series of statistics to determine whether these proportions are higher than in the past. However, it seems evident from the CCMC and later surveys that, as other sources of poverty have been alleviated, the poverty population has become increasingly a sick and disabled population relative to the rest of society. In fact, there may be a *countercyclical* link between poverty and health: The more prosperous the economy, the less healthy the poor appear—because unemployment and other causes contribute less significantly to low income. The less prosperous the economy, the healthier the poverty population seems—because the poor then include more people whose incomes have been reduced by causes unrelated to their own health.

The implications of this countercyclical relation for the increased use of medical care by the poor in the postwar period should be evident. Most of the research on utilization assumes that the poor of one decade are the same people who are poor the next decade. Yet, to take the most recent period, there was an enormous reduction in the poverty population from 39.5 to 25.4 million from 1959 to 1969, or from 22.4 to 12.1% of the American people. This was a considerable achievement: Quite apart from the new medical care programs, it probably accounts for much of the improved access to health care. But at the same time, as the poverty population diminished, its composition changed. It continued to become increasingly urban (which put the poor into closer reach of medical services), and it also seems to have included an increasing proportion who were disabled or chronically ill. Despite the general improvements in health during the 1960s and the special efforts to improve the access of the poor, their health relative to other groups seems to have become worse. For example, low-income persons had 66% more “bed disability” days per person than high-income persons in 1957-61, but by 1972 they had 123% more such days.³⁶

³⁴U.S. Bureau of the Census, *Characteristics of the Population Below the Poverty Level: 1978*, Series P-60, No. 124, July 1980, p. 34. The proportion of the poor with a working head of household dropped from 75 to 60% between 1959 and 1976.

³⁵Harold S. Luft, *POVERTY AND HEALTH: ECONOMIC CAUSES AND CONSEQUENCES OF HEALTH PROBLEMS* (Cambridge: Ballinger, 1978).

³⁶These statistics need to be read with caution because the income categories in the two periods are not exactly comparable. However, the data do show an increasing slope in the sideways J-curve of income and disability, whether bed-disability days, inability to carry on major

The cause was probably not that the health of the poor declined, but that the concentration of unhealthy people among the poor increased as others stopped being poor.

Several studies have tried to determine whether the increased use of medical care by the poor adequately reflects their relatively greater need for services. Aday and her colleagues, adjusting use of physicians' services by number of days of disability, indicate that by 1976 no differences existed between different levels of income.³⁷ On the other hand, Kleinman, using a much larger survey for 1978, finds high-income people see physicians 73% more often in relation to a somewhat different index of need (bed disability days).³⁸ Other studies corroborate this picture. Despite improvements in access, lower-income people still seem to receive fewer services in relation to need.

There is, moreover, persuasive evidence of continuing differences in the quality of services received by the poor. Higher proportions of low-income persons receive medical attention in hospital outpatient departments, clinics, or emergency rooms—and those who are seen there express the most dissatisfaction with their experience. Higher-income persons (\$15,000 and over) take only 68% as long to travel to get to medical care and wait only half as long once they get there as lower-income persons (under \$5000), whose mean waiting time is over an hour.³⁹ Internists in practices with a majority of Medicaid recipients order injections for almost one-half of their office patients, a rate almost three times that of doctors who rarely see Medicaid patients.⁴⁰

activity, or limitation in major activity is used as an index. Compare National Center for Health Statistics, *Bed Disability Among the Chronically Limited, United States July 1957-June 1961*, Series 10, no. 12; and Department of Health, Education and Welfare, *HEALTH: UNITED STATES*, 1979, p. 117-18.

³⁷LuAnn Aday, Ronald Andersen, and Gretchen V. Fleming, *HEALTH CARE IN THE U.S.: EQUITABLE FOR WHOM?* (Beverly Hills, CA: Sage Publications, 1980).

³⁸See the data in Karen Davis, Marsha Gold, and Diane Makuc, *Access to Health Care for the Poor: Does the Gap Remain?* ANNUAL REVIEW OF PUBLIC HEALTH (1982, forthcoming). The bed-disability index probably reflects the differences in health more accurately. Ordinary disability days show less variance by income because higher-income people include illnesses of lesser severity.

³⁹Frank Sloan and Judith D. Bentkover, *ACCESS TO AMBULATORY CARE AND THE U.S. ECONOMY* (Lexington, MA: Lexington Books, 1979).

⁴⁰Janet B. Mitchell and Jerry Cromwell, *Large Medicaid Practices and Medicaid Mills*, JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 244 (Nov. 28, 1980), pp. 2433-36. On most other indices, physicians serving Medicaid patients were not providing measurably lower-quality care. However, the Mitchell/Cromwell data came from the physicians' own responses to questionnaires.

The continuing differences in the access of the poor to medical care reflect the limitations of the programs established in the 1960s. As Karen Davis and her colleagues point out, Medicare covers less than half of the health expenditures of the elderly, Medicaid covers only one-third of the poor, and neighborhood health centers only reach an additional 5%.⁴¹ Because of differences in eligibility requirements for Medicaid, the proportion of the poor covered varies enormously among the states. Medicaid omits from coverage most two-parent families and childless couples, widows and other single persons under 65 years of age, families with fathers who work at low-paying jobs, and medically needy families in the 22 states that do not provide such coverage.⁴² Aday and her colleagues, while producing evidence for a strong tendency toward equal access, identify the uninsured, including many low-paid blue-collar workers, as a group with limited access to medical care. And, similarly, a Yankelovich survey in spring 1980 found the highest level of dissatisfaction with medical care not among the poor, but among those with incomes between \$10,000 and \$15,000 a year.⁴³

So the structure of inequality seems to have changed once again. Instead of the marginal poor being excluded from access—as was the case in the postwar period—we now have a group of uninsured, working poor, often above the income levels of Medicaid recipients, neither poor enough to qualify for public assistance nor adequately paid to afford or receive private insurance. Along with those of the poor excluded from Medicaid because they fail to fit into eligibility categories, these are the medically excluded today—those who wander in what might be called the Medicaid-private insurance corridor. Also in the corridor are a variety of transients, such as the unemployed, who have lost their old insurance but have not acquired any other.⁴⁴ In some states, where the standards of need have been set at extremely low incomes, the corridor of the excluded is wide and filled with people. In other states, the income levels are higher and the corridor is narrower. But regardless of how wide it is, the corridor is a patently irrational and inequitable vestige of the resistance to universal health insurance. Even in this period of growing conservatism, we should be able to find the means to close it up for good.

⁴¹Davis et al., *Access to Health Care for the Poor: Does the Gap Remain?*

⁴²Davis and Schoen, *HEALTH AND THE WAR ON POVERTY*, pp. 52-56.

⁴³Health Insurance Institute, *HEALTH AND HEALTH INSURANCE: THE PUBLIC'S VIEW* (Washington, DC, December 1980), p. 8.

⁴⁴1975 data indicate that the unemployed had 34% more physician visits than the employed, but between 50 and 60% fewer when controlling for differences in health. See Sloan and Bentkover, *ACCESS TO AMBULATORY CARE AND THE U.S. ECONOMY*, p. 51.

Equity of Access to Health Care: Some Conceptual and Ethical Issues

B

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THE LITERATURE ON *EQUITY OF ACCESS* TO HEALTH care is complex and confusing. Indeed, there is no consensus on what equitable access involves. There are three central reasons for divergence on this question. First, *access* is itself a complicated notion, composed of many factors. Consequently, determining what counts as *equality* of access, let alone *equity* of access, is a nontrivial problem; moreover, in some cases considerations about equity already play a role in our judgments about equality. Second, health care services are nonhomogeneous. They have many functions, some more important, more basic, or more urgent than others. So it is not possible to settle questions about equity of access until we have made it clear what the access is *to*. Are we worried about access to all the services offered in our health care system? Or are we worried only about a key set of services, defined by reference to some central or basic function, regardless of their availability within our system? And how can we pick these out in the context of an evolving system and technology? Third, and perhaps most fundamental, divergence on what to count as equitable access derives from divergence on more basic moral questions, specifically questions of distributive justice. There is moral disagreement about the nature of health care as a social good, about what sort of special importance, if any, attaches to it. Moreover, disagreement on this question is tied to other fundamental disagreements about what distributions of social goods are just.

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I shall organize my remarks as follows. In Section I, I shall briefly explain why the problem of defining equality of access is not trivial. This point runs counter to the view that we have a clear, noncontroversial notion of equality of access and that our only disagreements are about which departures from such equality are morally acceptable. In Section II, I shall discuss three approaches to the definition of equity of access. These include the utilization and needs-based account of Aday and Andersen (1980), a more "process"-oriented approach of some of their critics, for example, Sloan and Bentkover (1979), and a distinctively different "market"-based account, variants of which abound in the medical economics and planning literature. (I shall here include Enthoven, 1980.) I shall look at the strengths and weaknesses of each of these approaches and suggest ways in which their fundamental differences depend on broader disagreements about the nature of health care as a social good and about other principles of distributive justice. In Section III, I shall take up the question: to what must we have access? Specifically, I will look at the presuppositions about equity underlying reform proposals such as those advanced by Enthoven. These are important because they force us to consider the view that equitable access is access to a "decent basic minimum" of health care. I shall then sketch an account of a theory of distributive justice which avoids some of the problems facing the approaches to equity of access that we will have considered, though it leaves some issues unresolved. Finally, in Section IV, I shall comment briefly on the relationship between the demand for equity of access and other issues of distributive justice that arise in the assessment of a health care system.

A note on terminology is in order. In this paper, the term "equity" is used in a broad sense and is roughly equivalent to "distributively fair or just." There is also a narrower usage in which equity is an "interstitial" concept, one that raises questions of justice only against a background of institutions whose conformance with principles of justice is not at issue (cf. Barry, 1965:1522ff.). I use the broader notion, though I might prefer to restrict "equity" to the narrower one, because the literature on access to health care seems to employ the broader concept.

I. When Is Access Equal?

Equal Income versus Equal Access

It is tempting to think that we can give a completely noncontroversial definition of equal access to health care—much as we can do for equality of income—and reserve all controversy for debates about

which departures from equality conform to acceptable principles of justice. Suppose I earn \$10,000 less than you. The inequality might be thought *equitable* by some if you work longer or harder than I; by others, if your skills have a higher market value than mine; and by others, if you need more than I do. Here our moral disagreements about appropriate distributive principles show up as disagreements about just or *equitable* income distribution, though there is no controversy about whether or not our incomes are equal. The situation is arguably different for the notion of equal access: to arrive at a notion of equal access, we must already have made various decisions about what kinds of considerations ought to count in judging when access is equal. These decisions reflect our purpose or interest in making the judgment about equality, and some of these discriminations are themselves of a moral nature. Moral considerations, then, are already included in the specification of equality and are not held at bay until we get to decisions about equity.

Consider the problem in a slightly different context. There is a coffee supply in a lounge not far from my office. When is access to the coffee equal among my colleagues? Some cases seem clear: if the lounge is open only to male colleagues, then female colleagues can complain they do not have equal access to the coffee. If the lounge is up a flight of stairs and there is no wheelchair ramp, then my paraplegic colleague may have ground for claiming unequal access to the coffee. After all, he has to ask someone to fetch it, but none of the rest of us do. (Does his complaint disappear if in fact he drinks as much coffee as we do?) Other factors have a less clear impact. Should we worry about the fact that not all offices are equidistant from the pot? Some are thirty feet away, some only ten. Does it matter how the offices were assigned, randomly, by choice, or by seniority? Does it matter if the distance correlates negatively with coffee use? Should we worry that some colleagues use more calories in walking to the pot than others? Suppose the lounge is painted a brilliant green, a color I so dislike that it takes more psychological effort for me to fetch coffee than it takes my colleagues, who chose the color. Is our access unequal? Suppose that on a previous job, I had unpleasant coffee room experiences and their memory hinders me from getting coffee; my colleagues had pleasant coffee room experiences. Do we have equal access?

I am not suggesting we spend much effort figuring out when access to the coffee is equal, for I do not want to trivialize the problem of access to health care. Still, it is worth seeing what underlies my inclination to say that the access to the coffee is *equal* despite variations in office distance, use of calories, preference for the color of the lounge, or past experiences that influence preferences. Where we have something that is merely an amenity (this is not an honest statement of

my feelings first thing in the morning!), variables that merely affect preference orderings are properly ignored in judging equality of access. Factors like the "male only" lounge or the flight of steps have an impact in a way independent of effects on preference orderings. If I felt differently about the importance of coffee, because I thought it met a basic need (let us ignore habit or addiction), I might be more sensitive to factors that affect preferences and I might want to make finer discriminations, especially where there is an effect on utilization of the coffee pot.

My assessment of the importance of the coffee is connected to other views I have about which variables affecting access or use are relevant to issues of *equity*. That is, I allow my notion of *equality of access* to be determined, in part, by *prior judgments about equity of access*. Lest the case of the coffee pot be suspect because of its triviality, consider the same point in a nontrivial context. Thus, one tradition in our society is content to judge that equality of opportunity obtains if there are no formal—for example, legal or quasi-legal—barriers to persons of different races or sexes competing for a job or office. Others argue that positive steps must be taken to compensate for various natural and social variations between people which arguably confer "unfair," or at least undeserved, advantages. On this view, unless the impact of this "natural lottery" is compensated for, equality of opportunity does not obtain (Rawls, 1971:Sect. 14,17). Clearly, this difference in judgment about what counts as equality of opportunity is itself the product of other moral assessments, and so the notion of equal opportunity is itself controversial. Consequently, it cannot serve (without further argument) as a noncontroversial baseline which we can use in debating the equity of inequalities in opportunity. The case is the same, I am suggesting, for equal access to health care.

Equal Access: Moral Complaint or Moral Ideal?

A related point is worth making before beginning our discussion of various approaches to defining equitable access. In a broad range of settings, individuals and legislators talk as if there is agreement on what would count as equal access. Thus, we find the remark in the Health Planning Act of 1974 (P.L. 93-641) that it is an important objective of federal policy to provide "equal access to quality care at a reasonable cost." It is probably fair to say that *all* that most people have in mind when they talk about equal access is a negative criterion, specifically that certain traditional constraints on access, mainly financial and geographical, should play a minimal role in determining whether people who need health care get it. There *may* be implicit

in this negative characterization a positive ideal: for example, "any two persons of comparable health status who want appropriate care have an equal chance of getting it." But nothing so schematic may be in anyone's mind at all; there may only be a moral complaint against a *particular inequality*. This point might be fruitfully expanded by a careful look at the history of our concern for equal access (cf. Starr, 1981).

II. Three Accounts of Equitable Access

Equity as Utilization for Need

The Aday and Andersen Approach as an Analytic Framework. I turn now to examine the ethical presuppositions and implications of three accounts of equitable access, a use- (or use-per-need) based account, a "process" variable account, and what I shall call a "market" account. The framework provided by Aday (1975), Aday and Andersen (1974, 1980) and Andersen et al. (1975, 1976) is a useful place to start. Not only is their work seminal, but seeing what motivates their project will allow an economical discussion of the alternative approaches. I stress that my goal here is to point to ethical implications of the work, not to undertake a systematic, empirical assessment of it. Moreover, I must confine myself to the central thrust of each approach and not the subtle ways in which the accounts may be refined, extended, or combined. My central point will be to show the way in which accounts of equitable access are really disguised ways of talking about principles of distributive justice for health care.

Aday and Andersen's (1980) work has both an analytic and normative importance. To see its analytic function, consider the fact that alternative theories of the behaviors or processes through which people seek health care suggest many factors which *could* have an effect on the use of health care services. We need a way of testing to find out which factors *actually do* have a significant effect on access. These *potential access* factors are of two, and by some classifications, three kinds. Some are *structural* features of the health care system, such as the availability of physicians or hospitals in different geographical areas, as measured, say, by physician-patient ratios. Others are features of *individuals* in the population including predisposing factors, such as age, health status, and cultural background, and enabling factors, such as income or insurance coverage levels. A particularly important subgroup of factors is sometimes viewed separately and called "process" factors. They play an important role in the process of seeking health care, at least in some theories of the process. The analytic task is to decide which variations in these many factors influencing *potential*

access are important. Which ones count because they really contribute to differences in access to health care?

Aday and Andersen seek to test the importance of potential *access* variables by determining their effect on the measure of actual or *realized access*, the output of the system. Measures of realized access are of two main types: *subjective* measures concern satisfaction with treatment; *objective* measures are concerned with various utilization rates. The overall strategy is thus to look at variations between population subgroups on some measure of potential access to see if there is an effect on realized access, here utilization rates. Suppose our working theory of the process through which we seek health care suggests that a certain variable—say waiting time for an appointment—will have a big effect on access to health care. Aday and Andersen propose a method for “testing” such claims: Potential access variables are important only if they produce an intergroup effect on realized access (utilization rates). If a process variable—say waiting time for an appointment—does not have an effect on utilization rates for population subgroups, then it is not causally significant according to the criterion being proposed. So the utilization rate test is a way of saying that the proof of the pudding is in the eating; the test of access is use.

Of course, details become important here. A process variable—for example, time spent in a waiting room—may have a significant effect on measures of satisfaction with care, but has relatively little effect on utilization rates. So the choice of objective or subjective measures of realized access may yield different assessments of the importance of a process variable and, ultimately, of the equity of access to health care services. In contrast to Aday and Andersen’s primary emphasis on utilization rates, some critics, who are particularly interested in process factors, tend to emphasize satisfaction measures (cf. Sloan and Bentkover, 1979). Even if we are inclined to use an objective measure, however, it matters which one. For example, utilization rates between income groups do not seem to vary significantly following the introduction of Medicare and Medicaid. But if health status of lower income groups is lower than that of higher income groups, there may still be variation in a measure of use per need, say use per disability days.

Aday (1975) and Aday and Andersen (1980) urge use of a measure of utilization per need. Even here, detail matters. Different measures of need, say a more complex measure than disability days, which Aday and Andersen use, might give different utilization-per-need rates and thus a different assessment of which variables are “important” in the sense so far discussed. For example, if some income or cultural groups inflate their disability days, say because of different attitudes toward adopting a sick role or different absenteeism incentives’ (cf.

Sloan and Bentkover, 1979:3), we may find that measure of need to be problematic for the analytic task at hand. Similarly, Davis et al. (1981) suggest that the choice of *bed-disability days* as a measure of need reveals a difference in use per need between high- and low-income groups which is not apparent with the less severe measure of need, disability days.

It is important to see that the focus on use per need rates stops short of measuring possible differences in the *efficacy* of the services delivered to different population groups. It is at least conceivable that use-per-need rates could be similar, but the quality—here, efficacy—of the services might vary, so that use per need would not effectively measure impact on health status. This point bears on the relevance of the focus on use-per-need rates and on the ultimate rationale for the definition of equity based on use.

Normative Use of the Account. It is crucial to see that the framework Aday and Andersen advocate is advanced primarily for its *normative* implications, not merely for its relevance to understanding or describing the causal relationships among the phenomena involved in access to health care. Indeed, we find the analytic test for the causal importance of a potential access variable reformulated as a definition of equity of access. Aday and Andersen argue: "The greatest 'equity' of access is said to exist when need, rather than structural (for example, availability of physicians), or individual (for example, family income) factors determine who gains entry to the health care system" (1980:26; Andersen et al., 1975:10–11). In other words, access is equitable if the *important* potential access variables, as operationally defined, are all related to health status in the proper way. If, however, important potential access variables are not related to health status, then an inequity of access obtains. As Aday and Andersen (1980:43) put it:

Inequity in health service distribution occurs when individuals receive services primarily according to their place in the social structure, their enabling characteristics, or the characteristics of the health system instead of according to their need . . . The inequity may be only "apparent," however, if the lower access levels can be explained by varying age structure (demographic or illness levels). For example, lower use rates for an ethnic group consisting of predominantly younger persons in reasonably good health may be only "apparent inequity." Excess utilization is indicated if a subgroup has higher utilization rates than the rest of the population. However, like inequity, it may be only "apparent excess." One example would be higher utilization rates by the elderly which could be attributed to the larger number of symptoms and disability days they experience.

This normative account of equity of access is extremely influential. Davis et al. (1981), though they point to some "inequities" between

subgroups that Aday and Andersen (1980, 1981) fail to find, nevertheless appeal to the underlying Aday and Andersen definition. The difference lies in how the estimate of need is measured or operationalized.

The Argument from Function. The attempt to recast the utilization-rate test for important potential access variables as a normative criterion for equity of access needs justification. Why ought we to look at variations in utilization rates in this way? Here Aday and Andersen draw on a widely held view, namely that an "equitable distribution" of health care services is one in which illness (as defined by the patient and his family or by health care professionals) is the major determinant of the allocation of resources" (1980:41).

One common way to defend this view involves an *argument from function* which goes something like this:

The (main) function of health care services is to prevent and cure illness, i.e., to meet health care needs. A distribution of health care services that is not determined by the distribution of health care needs is therefore unreasonable in some important sense. Specifically, it ignores *similarities* and *differences*—in health status—between persons that, given the function of health care, ought to be relevant to establishing its reasonable distribution. Ignoring such relevant similarities and differences makes a distribution inequitable.

Something like this argument is clearly foreshadowed in Bernard Williams's now classic discussion of equality in which he concluded that "leaving aside preventive medicine, the proper ground of distribution of medical care is health care; this is a necessary truth" (Williams, 1962:27). In any case, of course, the argument at most establishes a *necessary* but not a *sufficient* condition for equitable distributions. Moreover, some would argue (as we shall see) that it is not even a necessary condition for equity that health care be distributed according to needs for health care. For example, some might object that the argument mistakenly presupposes that health care services are homogeneous in function and that people will always have preferences that correspond to their presumed health care "needs."

This underlying view, resting as it seems to do on an argument from function, is a central and powerful one. It is a view with a long history of advocacy. I shall come later to sketch a position which incorporates those aspects of it I think correct. Still, we can see it is not the whole of the story, if we examine more carefully some objections to the Aday and Andersen approach.

Objections to the Utilization for Need Account. One central objection is that a focus on utilization rates ignores at least one other necessary condition for equity of access. Specifically, variations in certain potential access variables, especially process variables, can have equity implications even if they do not show up as important variables on

the Aday and Andersen criterion, that is, by reference to their effects on utilization rates. Time spent in a waiting room, or out-of-pocket health care expenditures, if they vary with income group (corrected for health status), are *differentially burdensome* even if utilization rates (or use-per-need rates) are not affected. More generally, someone may argue that some inequalities in potential access variables between subgroups raise equity questions even if they do not affect the outcomes of health care seeking behavior, as measured by utilization rates. They still affect other outcomes: for example, what else someone has the chance to do with his time or money.

A second objection is that subgroup uniformity in utilization rates (or use-per-need rates) is not even a necessary condition for equitable access. Some subgroup variations that correlate with utilization rate differences will reflect differences in *attitudes* toward health care. Consequently, these variations may not be inequities in the access to health care at all. A standard example might be the deliberate under-utilizer who, for religious, esthetic, or cultural reasons has a principled aversion to some or all traditional (mainstream) health care services. Another form the problem may take has already been mentioned. Attitudes toward assuming a sick role may differ between cultural or income groups, so that some judge themselves to have a disability day more readily than others. But if one group inflates its needs in this way relative to another, the equity of the distribution is affected. (Cf. Sloan and Bentkover, 1979:3.) Of course, we need to draw finer distinctions, say between those attitudes toward health care based on ignorance, which society has a responsibility to correct, and those based on principled, informed choice. But clearly, some modification of the Aday and Andersen account is needed to accommodate these worries. In any case, they clearly leave room for such a modification.

The issue is even more complex, however. It may be that *some* variation in utilization rates, even corrected for health status, is not importantly related to *health outcomes*, that is to health status after treatment. It is at least arguable that only those utilization rate variations are inequitable which reflect significant differences in the preventative, curing, and caring functions of health care services. Aday and Andersen shy away from looking at health outcomes because so many factors intervene between utilization and outcome; but their simplification here may leave room for a systematic bias. The kind of case of greatest interest is one in which one treatment is more intensive than another but where there is no evidence that it is also more efficacious. The issue arises, for example, in the context of mental health care, where some evidence points to the use of more intensive interventions (therapy) for upper-middle-class groups and low intensity (more drug oriented) treatments for low-income and minority groups (cf. Mollica and Redlich, 1980). If there is no de-

monstrable difference in efficacy between the two types of treatment, does the inequality in utilization rate by income group constitute an inequity? Finally, one might insist that some differences in utilization rates, even where there *are* effects on health status outcomes, reflect informed choices about how risk-free one wants to be. They reflect a choice about how important one thinks health care services are compared to other things on which one may want to spend income (cf. Fried, 1978). Such choices may well lead to utilization-rate differences, but they still do not indicate inequity of access.

It is now possible to explain what I am calling the “process” and the “market” accounts of equity of access in terms of the possible objections to the utilization rate account that we have just noted. Minimally a process account seems committed to the view that the utilization rate account captures *at most* one necessary condition for equitable access and, in any case, fails to capture another necessary component of equity, intergroup equality in process variables. Indeed, the process account may even drop intergroup uniformity in use-per-need rates as a necessary condition for equitable access. In this case, the process account clearly overlaps what I am calling the “market” approach, for the latter insists that uniformity of use per need is not even a necessary condition for achieving equitable access. Of course, the market approach parts company with the process account in that it also rejects the view that intergroup variations in process variables constitute inequity of access.

Equity as Equality in Process Variables

Sloan's and Bentkover's Account. Consider as an example of the “process” approach Sloan's and Bentkover's (1979) fine study of access to ambulatory care. Their view is not so much that one should ignore utilization rates, which they admit are an important measure of realized access. Rather, they object to its selection as the sole or even primary criterion in an account of equitable access (1979:2–3). Their concern for the way in which certain process variables—for example, travel or waiting time—may vary with income group, race, or geographical area is a concern for what they refer to as the “humaneness” of the care delivered (1979:4). Presumably, such variations are likely to be captured more by *subjective* (satisfaction) measures of realized access even when they do not affect *objective* (utilization rate) measures. Process variable differences, even where they do not affect utilization rates, may reflect differences in the difficulty of seeking care, that is, inequalities in the burdens that attend seeking care. As Sloan and Bentkover put it: “Many, for example, would view the long waits the poor experience in clinics as an injustice, irrespective of the effect

patient waiting might have on utilization rates" (1979:24). Gutmann, 1981, seems to suggest a similar view. The basic contention is that *access* to health care cannot be considered equitable if it is much more difficult for some people to get care than it is for others, even if people make adjustments to the burdensomeness of the process and get the amount of care they need.

Amenities, Quality, and Claims to Access. There is a certain plausibility to this worry about the burdensomeness of the process of seeking care and the claim that considerations of equity are raised by such differences. What is missing, however, is the kind of moral argument we saw was immediately forthcoming in support of the utilization rate approach. What we need to know is *why ease of access* must be roughly equal for population subgroups *even when the "ease" factor does not affect utilization rates*. The problem is made more glaring by a formulation of the issue which can be found in Sloan and Bentkover themselves. Specifically, they tend to group the impact of these process variables under the heading of "quality" factors in health care. Indeed, within their economic model, the term "amenities" is used (1979:24–25). The picture that emerges is that health care for some population subgroups may have more "amenities" than for other groups—for example, less travel or waiting time, more physician contact time—though not necessarily higher utilization rates or better health care outcomes. Do these subgroup differences in "amenities" constitute inequities of access? If the "process" account of equitable access can be construed as asking for a more egalitarian distribution of these amenities, and not just of utilization-per-need rates, what justifies the demand?

The problem here is that *only some qualitative* aspects of health care services clearly seem directly relevant to worries about equity of access. It is worth noting in this connection an important simplifying assumption that underlies the utilization rate account we have looked at. Utilization rates tell us nothing about the *quality* of the services rendered, where quality is some measure of net benefits minus harms (cf. Donabedian, 1979 and Daniels, 1981b). Such a measure of quality is largely concerned with the efficacy of services rendered. The simplifying assumption is that when use-per-need rates are roughly equal, we are dealing with qualitatively equal sorts of services, in the sense that their impact on health outcomes is likely to be roughly equal. But the "amenities" involved with many of these process variables, when they are viewed as qualitative features of the health services rendered, are *not* clearly linked to health status outcomes—only to subjective measures of satisfaction with the treatment. So an argument that grants health care services a very special status because of their primary function of meeting health care needs does not by itself seem powerful enough to justify the concern, present in the process account,

that the equal distribution of amenities is also a necessary condition for equity of access.

A more promising line of argument for the process account might go something like this. In order to be sure that variations in use-per-need rates are in fact the result of informed choices or preferences about the use of health care services, we must be sure that decisions to utilize are not made harder for some persons than others because of variations in the process variables. But the force of this argument is not obvious in the face of evidence that use-per-need rates are equitably distributed, because it still must be argued that we have a difference here that makes a difference. Still, variations in process variables are a useful focus of concern when an attempt is made to explain away a variation in use-per-need rates—for example, by saying they are merely the result of differences in preference. Such an argument puts the process account more in the role of an opponent of the market view than an opponent of the use-per-need account.

Of course, strongly egalitarian views about distributive justice in general might be invoked to justify a concern about equality among process variables. If, for example, one were prepared to argue that only differences in need or preference should be allowed to explain variations in the services used by different groups, then systematic variations in even “amenities” would look like inequities, just as unequal distributions of *any* goods that cannot be fully accounted for by need or preference differences constitute inequities in distribution. Or if one were to allow inequalities only if they act to maximize the well-being of the worst-off, then some variations in “amenities” might count as inequities. But I am not concerned to discuss such strongly egalitarian views here, largely because I am interested in the special arguments people are inclined to make about equity with regard to health services which they are not inclined to make for many other social goods. Still, more specialized arguments may be invoked here. Dickman (1981) argues that a principle requiring us to show “equal respect for persons”—plus the fact that people in need of health care are especially vulnerable to affronts to their self-respect—requires that we pay special attention to the roughly equal distribution of at least some reasonable set of “amenities.” Interesting though the argument is (also cf. Jonsen, 1976), I cannot consider it here.

Equity as the Market Availability of a Decent Basic Minimum

Constraints on the Market. I should like now to sketch in more detail what I have called the “market” approach to equity of access. In contrast to the utilization rate and process variable approaches, the

market approach is not really a position represented in the empirical literature on access. Rather, it is a composite abstracted from views which are common in economic and health planning literature. It is of interest here because of the quite different limits it places on the notion of equitable access and because of its quite different underlying view of health care and distributive justice. Nevertheless, as with the utilization-rate approach in particular, an underlying approach to issues of distributive justice plays a prominent role in defining what counts as an equitable access.

I have already noted that one common line of objection to the utilization-rate approach is that similarity in intergroup utilization-per-need rates is not even a necessary condition for equitable access (or distribution). A view that provides a rationale for such a claim is the view that health care services are commodities like any others. On this view, there is nothing so "special" about these services that cannot be accommodated by allowing markets to respond to people's preferences. Thus, equity of access is assured if three main conditions obtain: first, the commodity must be available at something like "true social cost"; second, individuals are capable of making rational informed decisions about using the system; third, income distribution must be approximately equitable. The second condition requires that information about alternatives—for example, therapies or insurance schemes—is available and that people are competent and informed enough to make use of such information. Some access inequities arise when this condition is not met and these must be addressed by public policy. But I will say nothing about them here.

Aside from the problem of subsidies to the poor to guarantee equitable income distribution, the central problems of access are those brought about by departures of the medical market from the ideal of a truly competitive market (cf. Arrow, 1963). In particular, there may be various distortions on the supply side which amount to the market not delivering services at their "true social cost." For example, some groups—rural populations or inner city minorities—may not be able to get the care they want and can pay for. They may not be able to get it in the desired quantities, or at the desired times, with the characteristics they desire. Viewed in this way, the problem is that the market is unresponsive to consumer preferences on the supply side, and interventions may be needed to correct the problem, generally by addressing structural problems—for example, obstacles to manpower supply, or problems in capital expenditure policy. A central problem here is the way in which the choice of a health insurance plan is tied to features of employment and the unavailability of an adequate range of plans—for example, ones that cover people between jobs. One structural feature of the insurance market is the relative unavailability of prospective per capita, rather than fee-for-service,

schemes; this feature is a central focus of criticism by a number of planners (cf. Havighurst, 1971 and Enthoven, 1980). The central issues of access and equity of access are concerned with these supply malfunctions of the market.

The third condition, equitable income distribution, usually requires only that no one fall below the officially defined poverty line. The assumption is that one can buy a subsistence level of basic social goods (food, housing, health care) and that transfers should make sure every one can. Moreover, it is usually insisted that the sum of cash and aid-in-kind benefits to the poor not produce work disincentives. Where this ceiling is not argued for just on efficiency grounds, it is also claimed that an inequity would result if employed workers were less well-off than the unemployed poor. Much could be said about the adequacy of these views of equitable income distribution, but this is not the occasion (cf. Brown et al., 1981; especially Daniels, 1981c).

One real issue that concerns us here is how to characterize the cash, voucher, or aid-in-kind transfer needed to meet these assumptions. The position that seems to be held in common—either explicitly or implicitly—by many “market” proponents is that the transfer must be adequate to buy a “decent basic minimum” of health care. If the transfer falls short of this, it is agreed we have an inequitable transfer. So the market view I am sketching is not that of the pure libertarian who might reject all such transfers, but rather one that marks an implicit acceptance of some important moral claims that might loosely be characterized as welfare rights. I shall examine the problems involved in characterizing the decent basic minimum in Section III, but in any case it seems clear that there are definite limits to the transfer needed in order to assure that equitable financial access to the medical market place is provided.

Implications of the Market Account. Assuring equitable access in the ways defined by the “market” approach leaves extensive room for all sorts of departures from equitable access as defined by either of the other two approaches we have considered. Surely, there may be variations in the “amenities” that accompany health care services, if that is how we want to look at some process variables. Equal *quality* in these dimensions is surely not required, just as not everyone “prefers” equal quality in automobiles. Similarly, utilization-per-need rates may vary with “suspect” variables, like income or race, and yet not indicate any inequity of access, contrary to the Aday and Andersen formulation. Rather, the unequal distribution of health care—in quantity and quality—is viewed merely as the expression of different preference curves, just as food budgets might vary among a welfare recipient, a factory worker, and a wealthy industrialist. If we take the underlying income distribution to be morally acceptable, its expression in terms of utilization of health services need indicate no inequity.

Put succinctly, then, the "market" approach I am considering here comes to this: access to health care is equitable if and only if there are no information barriers, financial barriers, or supply anomalies that prevent access to a "reasonable" or "decent basic minimum" of health care services. How plausible such an account is depends on the characterization of such a decent minimum and the moral arguments that provision of such a minimum is all that requirements of equity (justice) demand. The problem facing the "market" proponent thus appears to be the other side of the coin from the problem facing the utilization rate account. One central problem with that account was its simplifying assumption that health care was relatively homogeneous in function and that the proper basis for its distribution must be the realization of that function. If, however, we want to treat health care services as nonhomogeneous in function, and we are willing to ground equity claims only by reference to some features of some of those services, we must present an account of how to draw the lines.

A Pragmatic Remark

Before looking at some of the ethical issues involved in the attempt to define equity of access by reference to some decent minimum, it might be worth commenting on a more pragmatic approach. One might suggest that even if disagreements about equity of access are rooted in fundamental disagreements about distributive justice, there may still be points of agreement as well. Are there points of agreement among the different approaches about inequities in the existing health care system? Indeed, some might argue that matters of public policy in the face of fundamental disagreement must rest on principled compromise, and we should look solely at the points of convergence between them.

A careful empirical survey of the literature should readily isolate major points of convergence. I leave that task to someone more competent in assessing the empirical literature. Indeed, a careful reading of Enthoven (1980) suggests where some of those points of convergence lie.

III. Decent Minimums and the Requirements of Justice

Problems of Characterization

Lists versus Criteria. Earlier I noted that there is a basic question which must be answered before we can understand disagreements

about access: access is always access *to something*, but to what? There is a tendency in the utilization and process variable accounts to assume that the answer must be "access to whatever range of services are available in the system." This answer ignores the nonhomogeneity of function of health care services and systems. In contrast, the market approach circumscribes the demands of equity with regard to access in a way which may avoid this objection. It insists that we are concerned only with access to a "decent basic minimum" of care. I want here to examine some of the problems with this notion.

What is meant by a "decent basic minimum"? There are three ways to elucidate the notion: 1) the provision of a general *criterion* by reference to which we can tell if services are among the minimum or are above it; 2) the description of a fair *procedure* for determining the minimum; or 3) simply listing the types of services included. In the market literature, indeed in much of the literature, there is little attempt to give a general criterion or describe an appropriate, fair procedure. What attempts we get are far too vague. Charles Fried (1976:32), for example, suggests the "decent minimum should reflect some conception of what constitutes tolerable life prospects in general. It should speak quite strongly to things like maternal and child health which set the terms under which individuals will compete and develop." There may be the nucleus for a helpful idea here, but it is not developed enough to tell us when prospects are tolerable. As John Arras (1981:32) asks, tolerable to whom?

More specific is the characterization that emerges from Enthoven's (1980) discussion of a Consumer Choice Health Plan. To qualify for tax credits, vouchers, or Medicare payments, an insurance plan would have to meet certain requirements. "A qualified plan would be required to cover, at a minimum, the list of services called 'basic health services' in the Health Maintenance Organization (HMO) Act of 1973 (as amended). This list includes physician services, inpatient and outpatient hospital services, emergency health services, short term outpatient mental health services (up to twenty visits), treatment and referral for drug and alcohol abuse, laboratory, and X-ray, home health services, and certain preventive health services" (Enthoven, 1980:128). Enthoven adds, however, that "it might make sense to start the program with a less costly list" (1980:128), that, unfortunately, leaves the specification by list indeterminate, a point to which I shall return shortly. Qualified plans would be required to offer a low-option plan, consisting of just the basic services (or an acceptable subset of them), in addition to any higher-option plans they market.

If we recall our earlier analysis, equity of access is guaranteed on the market approach if there are no important information, financial, or structural obstacles to buying into a low-option plan. Enthoven

suggests that structural barriers will be reduced if qualified plans are required to have "open enrollment" to all eligible in its service area and "community rating" to avoid division of qualified plans into high and low risk groups. Furthermore, breaking the connection between employment and type of insurance plan available will remove another anomaly of the insurance market and close an important gap in access. Enthoven assumes that using vouchers to enhance the purchasing power of rural areas, which have relatively poor populations, will improve the availability of services. One must ask, however, whether or not open enrollment is sufficient guarantee that plans are available to all in an area; should there be requirements on demographic mix or on option mixes (cf. Havighurst's [1971] idea of a 50% nonvoucher requirement on membership)? Similarly, we must know how well manpower and facilities will be disseminated geographically merely because vouchers increase purchasing power in underserved areas. Whether Enthoven's measures are adequate to eliminate structural problems affecting access I leave to a more empirically focused discussion. Instead, I return to the question of what equitable access is access to.

Low and High Option Plans. Consider again Enthoven's effort to specify the decent minimum by reference to a list. The list is open to emendation; not everything on the 1973 HMO Act list is mandatory. By virtue of what are things on the list in the first place? By virtue of what can we leave them off? Can we leave mental health coverage off? Dental care is already omitted. Why should things be on or off? It should be remembered that we just cannot determine *the list* by reference to average costs for actuarial categories. These costs are merely the costs for types of services—for example, physician or hospitalization. When Enthoven (1980) uses the figure of \$1350 for a family of four for the voucher available to a family with a maximal total income of \$4200, the figure is based only on actuarial costs for physicians and hospitalization. So we have to know what is to be on the "decent basic minimum" list before we calculate the voucher. Unfortunately, we have been offered neither a principle nor a fair procedure for arriving at the list.

Consider now some ways in which low option plans might differ from high option plans. The indeterminacy of what must be included in the low option plan will of course show up as an equity of access question if more comprehensive plans include broad categories not included in basic plans—for example, mental or dental coverage. But comprehensiveness can vary even within categories. What surgical procedures are covered? What mental health therapies? What dental plans?

There are other important ways in which low and high option plans

may vary. Suppose the extensiveness of diagnostic services is allowed to vary between lower and higher budget plans. Then we might imagine persons with similar health status being given less or more extensive diagnostic services. One way to conceptualize this variation is as a variation in quality, here taken to be a measure of the net health benefits minus burdens (cf. Donabedian, 1979). If we imagine that, under different budget ceilings, quality can be optimized in different ways, we return to our fundamental problem. Suppose, for example, one quality optimization, available under a high option plan, allows some greater degree of freedom from risk, say of risk of undiscovered cancer, than is available under the low option plan. We can imagine people thus "buying" a degree of freedom from risk, so that people who like to be relatively risk-free would buy the high option plan, while those who want to tolerate a greater risk would buy the low option plan.

Do we now have an equity of access problem? The decent basic minimum approach would, at least implicitly, be setting a degree of freedom from risk against which it is "decent" to be protected. Anything higher must be viewed as a matter of preference—a commodity to be floated in the market. But it is not clear that we have any such clear idea of a decent minimum. No doubt some of the variation here would be curtailed by malpractice litigation, but it is also not obvious that this litigation is the proper forum in which to decide these matters of health policy. Nor is it obvious that we can appeal to "standards of practice" to resolve this question. Where such standards are based on good studies of efficacy and cost-effectiveness, we may resolve some issues. But where the standards are derived from a clinical practice setting in which reimbursement is generally on a fee-for-service basis, the issue of what standard is acceptable under different budget ceilings has not been squarely faced. Of course, where the differences in "quality" are primarily of the sort Sloan, Bentkover, and others worry about under the heading "amenities," we can expect the "decent minimum" standard to allow some care to be considerably less decent than others.

My criticisms of Enthoven's characterization of the decent basic minimum are not responsive to one defense he might make. He might say that the decent basic minimum must be defined relative to existing practices within the society, specifically those that lead to the average actuarial costs for the items on his list. The decent minimum is defined by reference to the average. How can the worst-off complain if they end up doing as well as the average? Of course, this response ignores the flexibility of the list itself; still, it rests on a healthy pragmatism. To see that an account might aim for a more principled characterization of what justice requires, we must turn to an alternative view.

Toward a Distributive Theory: The Fair Equality of Opportunity Account

Is Health Care "Special"? My suggestion that the notion of a "decent basic minimum" is inadequate to support the moral weight it bears in the "market" approach is best supported by the proposal of an alternative account. It is possible to give a more perspicuous, if still abstract, account of what equitable access should be access to. My account (cf. Daniels, 1981a) is an attempt to answer the question: what is so special or important about health care compared to other social goods? Many people in many societies believe it is especially important, for they often insist health care be more equally, actually equitably, distributed than various other social goods. What might explain this special importance?

We need to back up a bit and consider more carefully the *function* of health care. Such an analysis is what was missing in the use-per-need account. Suppose we adopt a rather narrow, if not uncontroversial, view of disease: diseases will be departures from normal species functioning. Health care needs, broadly construed, concern things we need to prevent, maintain, restore, or compensate for—departures from normal species functioning. Why are such departures from normal functioning of social importance? One initially plausible answer is that, whatever else we need or want, we need normal functioning—it is a necessary condition for happiness, say. But this answer seems less plausible when we note that happiness or satisfaction in life do not so clearly require normal functioning. Many people "cope" well with significant impairments.

A more plausible answer, I believe, is that normal species functioning is an important component of the *opportunity range* open to individuals in a society. The opportunity range is the array of life plans that it is reasonable to pursue within the conditions obtaining in a given society. This range is, of course, relative to various social facts about the society—its stage of technological development, material well-being, and so on. Thus, similar impairments of normal species functioning might have different effects on opportunity range in different societies. But within a society, it becomes possible to give at least a crude ranking to the effects of different impairments of normal functioning in terms of their effects on the normal opportunity range. In turn, this gives us a crude ranking of the importance of different health care needs. Moreover, on this account, some uses of health care services—for example, some cosmetic surgery or some kinds of counseling—do not meet health care *needs*, but only certain other wants and preferences.

I am suggesting that we can account for the special importance ascribed to health care needs by noting the connection between meet-

ing those needs and the opportunity range open to individuals in a given society. This suggests that the principles of justice governing the distribution of health care should derive from our general principles of justice guaranteeing fair equality of opportunity (cf. John Rawls, 1971:Sect. 14). Specifically, health care institutions will be among a variety of basic institutions (for example, educational ones) which are important because they insure that conditions of fair equality of opportunity obtain. I cannot argue here the issues in the general theory of justice that would support the view that fair equality of opportunity is a requirement of justice. But if I am granted the assumption that it is, we have the foundations for important social obligations in the distribution of health care. Moreover, a concern for fair equality of opportunity—in theory if rarely in practice—has a long historical tradition in this country.

There are, to be sure, worries with my approach. For example, the notion of opportunity has to be age-relativized or it seems to embody a significant age bias—like productivity measures of the value of life-saving technologies (cf. Daniels, 1981d). Similarly, I must show that these requirements of justice do not open a bottomless pit into which we are required to pour endless resources in quest of an unreachable egalitarian goal. But this is not the place to consider even such important details, and I have discussed them elsewhere (cf. Daniels, 1981a).

Implications for Access. The fair equality-of-opportunity account of distributive justice for health care has several important implications for the issue of equitable access we have been discussing. First, the account is compatible with, though it does not imply, a multi-tiered health care system. In contrast, the “market” approach requires at least a two-tier system. Thus, my account shares with the market approach the view that health care services serve a variety of functions, only some of which may give rise to social obligations to provide them. The basic tier in my account would include health care services that meet health care needs, or at least important health care needs—as judged by their impact on opportunity range. Other tiers, if they are allowed, might involve uses of health care services to meet less important health care needs or to meet other needs and wants. My account leaves open the possibility that other tiers of the system might also be important enough to be given special precedence over other uses of social resources; but if they are, it will be for reasons different from those which give such precedence to the basic tier.

Second, the fair equality-of-opportunity account provides a way of characterizing the health care services that fall in the socially guaranteed tier. They are the services needed to maintain, restore, or compensate for the loss of normal functioning. In turn, normal functioning constitutes a central component of the opportunity range open

to individuals. This account is, to be sure, abstract. It requires moral judgment in its application. Still, it provides a principled basis for argument about what is included in the basic tier, a basis we found lacking in the notion of a decent basic minimum and in Fried's gloss on the notion of "tolerable life prospects."

Third, whichever way the upper tiers of the health care system are to be financed, there should be no obstacles—financial, racial, geographical, and so on—to access to the basic tier. The importance of such equality of access follows, I think, from basic facts about the sociology and epistemology of the determination of health care needs. The "felt needs" of patients are at best only initial indicators of the presence of real health care needs. Structural and other process barriers to initial access—for example, to primary care—compel people to make their own determination of the importance of the symptoms they feel. Of course, every system requires some such assessment, but financial, geographical, and other process barriers (waiting time, for example) impose the burden for such assessment on particular groups of persons. Indeed, where it is felt that sociological and cultural barriers exist preventing people from utilizing services, positive steps are needed (in the schools or through relevant community organizations) to make certain that decisions are informed.

The Aday and Andersen approach may be helpful here. Their utilization-per-need criterion, or a refinement of it, gives us a way of telling when a potential access factor is likely to be affecting opportunity through its impact on utilization rates. Moreover, whereas their unqualified assumption about the homogeneity of health care was problematic for the health care system as a whole, it is not problematic in this context. Indeed, my account characterizes that function in a perspicuous way, enabling us to see why it has special moral importance. In addition, my account permits "suspect" variations in utilization-per-need rates to be explained away as informed choice where this is plausible. (Aday and Andersen also leave room for such modifying explanations.) In short, I think the account I offer takes what is reasonable from the argument from function which underlies the utilization-per-need-account and provides a clearer moral rationale for it.

Fourth, the fair equality-of-opportunity account remains silent on what to make of demands for strict equality in process variables ("amenities"), that is, independently of their effect on utilization-per-need rates. It also remains silent on equity of access requirements for the upper tiers, if such there be. It also needs to be carefully applied if it is to answer the kinds of problems that I raised concerning the market approach with regard to variations in quality—that is, efficacy and protection from risk. These are not issues I am prepared to take a direct stand on here. Still, it is worth characterizing in

general terms the kinds of arguments that might be brought to bear. The crude typology of arguments I will suggest at least tells us what kinds of considerations we should avoid conflating.

A Typology of Arguments about Equality. Arguments about equity concerning "suspect" variations in "amenities" or in quality (protection against risk, for example) fall into three main categories. The first kind of argument rejects the inequality on general grounds of distributive justice, independently of the fact that we are concerned with health care. A *general distributive* argument, for example, might suggest that income inequalities of the sort the market approach tolerates, which do not allow some people to buy extensive amenities or superior quality, are not justifiable. One need not be a strict egalitarian here. Even a principle that constrained inequalities in the way Rawls's "difference principle" does, so that inequalities must act to make the worst-off groups best off, might not allow the kinds of inequalities tolerable to the "market" approach. Though I am inclined to take a rather egalitarian stand on income distribution, I find, for our purposes here, such general distributive arguments are not as interesting as arguments which more specifically address problems about health care.

Arguments that are directly concerned with health care can be divided into two kinds. A *primary* health care argument is one that asserts all health care services are special in some way and that this specialness forces us to be egalitarian in ways not necessary for many other social goods. For example, as we noted when we discussed possible rationales for the "process" account of equity, someone might argue that there is a special connection between health care and self-respect. Consequently, a society fails to show equal respect for persons if it allows inequality of access to even nonbasic health care services (cf. Dickman, 1981). Or some might argue that much of our health care manpower, facilities, and technology has at one point or another been heavily subsidized by public funds; consequently all citizens deserve equal access to what society has so extensively funded. The latter argument, it should be pointed out, is inadequate to justify equal access to health care in societies that have not subsidized their health care systems. My own suspicion is that primary arguments about equal access to all health care service are not likely to succeed. For example, they may assume a homogeneity of function for health care services which is contrary to fact; or the property they pick out—for example, public funding—also characterizes many things or institutions where no comparable argument about equal access is advanced.

Secondary health care arguments may hold more promise, but they are likely to rest on far more complicated and disputed empirical claims. For example, a secondary argument might advance a distinc-

tion between basic and nonbasic categories of health care services, or between adequate and above-adequate levels of quality. Still, because the tiers or sectors that deliver both kinds or qualities of service are causally connected to each other, by allowing a market for the nonbasic level, we might threaten the possibility of delivering the basic level equitably. For example, a market approach to nonbasic services might undermine the quality or raise the cost of the basic tier through drains on manpower and competition for resources (cf. McCreadie, 1976). Of course, counter-arguments of the secondary type are possible too. For example, it has been argued that a market tier above the decent minimum promotes innovation, or that prohibiting such a tier will generate a black market (cf. Fried, 1976).

My sketch of a fair equality of opportunity approach thus leaves some issues unresolved. Still, it may point the way toward taking the best from the various approaches that we have seen it is otherwise difficult to reconcile.

IV. Non-Access Issues of Equity in Health Care

My central point throughout this discussion has been that different approaches to defining equity of access to health care ultimately depend on different underlying accounts of the kind of social good health care is, and on appeals to different principles of distributive justice. I briefly sketched an approach that I believe is an improvement over existing accounts, though it too leaves some problems unresolved. It is worth pointing out here, by way of conclusion, that issues of equity arise in other contexts than in disputes about access. We get a very one-sided picture of what a theory of justice for health care requires if we concentrate solely on issues of access.

My account of health care needs and their connection to fair equality of opportunity has a number of implications for resource-allocation issues (cf. Daniels, 1981a, 1981b, 1982). I have already noted an important distinction between the use of health care services to meet health care needs and their use to meet other wants and preferences. The tie of health care needs to opportunity makes the former use special and important in a way not true of the latter. Moreover, we get a crude criterion—impact on normal opportunity range—for distinguishing the importance of different health care needs, though this falls far short of being a solution to many hard allocation questions. Three further implications are worth noting here.

There has been much debate about whether the United States health care system overemphasizes acute therapeutic services as opposed to

preventive and public health measures. Sometimes the argument is focused on the relative efficacy and cost of preventive—as opposed to acute—services. My account suggests there is also an important issue of distributive justice here. Suppose a system is heavily weighted toward acute interventions, yet it provides equal access to its services. Thus anyone with severe respiratory ailments—black lung, brown lung, asbestosis, emphysema, and so on—is given adequate and comprehensive services as needed. Does the system meet the demands of justice? Not if they are determined by the approach of fair equality of opportunity. The point is that people are differentially at risk of contracting such diseases because of work and living conditions. Efficacy aside, preventive measures have distributive implications distinct from acute measures. The opportunity approach requires we attend to both, equity of access as well as equity in the distribution of risk (Daniels, 1981e).

My account points to another inequity in allocation. One important function of health care services, i.e., personal medical services, is to restore handicapping dysfunctions—for example, of vision, mobility, and so on. The medical goal is to cure the diseased organ or limb where possible. Where cure is impossible, we try to make function as normal as possible, through corrective lenses or prosthesis and rehabilitative therapy. But where restoration of function is beyond the ability of medicine *per se*, we begin to enter another area of services—nonmedical social supports. Such support services provide the blind person with the closest he can get to the functional equivalent to vision—for example, he is taught how to navigate, provided with a seeing-eye dog, taught braille, and so on. From the point of view of their impact on opportunity, medical services and social support services that meet health care needs have the same rationale and are equally important. Yet for various reasons, probably having to do with the profitability and glamor of personal medical service and careers in them as compared to services for the handicapped, our society has taken only slow and halting steps to meet the health care needs of those with permanent disabilities. These are matters of justice, not charity. We are not facing conditions of scarcity so severe that these steps to provide equality of opportunity must be foregone in favor of more pressing needs. The point also has implications for the problem of long-term care for the frail elderly, but I cannot develop them here (cf. Daniels, 1981d).

A final implication of the account raises a different set of issues, namely how to reconcile the demands of justice with certain traditional views of a physician's obligations to his patients. The traditional view is that the physician's direct responsibility is the well-being of his patients, that (with their consent) he is to do everything in his power to preserve their lives and well-being. One effect of leaving all re-

source-allocation decisions in this way to the micro-level decisions of physicians and patients—especially where third-party payment schemes mean little or no rationing by price—is that cost-ineffective utilization results. In the current cost-conscious climate, there is pressure to make physicians see themselves as responsible for introducing economic considerations into their utilization decisions.

But the issue raised here goes beyond cost-effectiveness. My account suggests that there are important resource-allocation priorities that derive from considerations of justice. In a context of moderate scarcity, it is not possible for physicians to see as their ideal the maximization of the quality of care they deliver regardless of cost. Pursuing that ideal upsets resource-allocation priorities determined by the opportunity principle. Considerations of justice challenge the traditional, perhaps mythical, view that physicians can act as the unrestrained agents of their patients. The remaining task, which I pursue elsewhere, is to show the level at which constraints should be imposed so as to disturb as little as possible what is valuable in the traditional view of physician responsibility (cf. Donabedian, 1979; Daniels, 1981b).

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For and Against Equal Access to Health Care

C

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THERE IS A FAIRLY WIDESPREAD CONSENSUS AMONG empirical analysts that access to health care in this country has become more equal in the last quarter century. Agreement tends to end here; debate follows as to whether this trend will or should persist. But before debating these questions, we ought to have a clear idea of what equal access to health care means. Since equality of access to health care cannot be defined in a morally neutral way, we must choose a definition that is morally loaded with a set of values (Daniels, 1981b). The definition offered here is by no means the only possible one. It has, however, the advantage not only of clarity but also of having embedded within it strong and commonly accepted liberal egalitarian values. The debate is better focused upon arguments for and against a strong *principle* of equal access than disputes over definitions, which tend to hide fundamental value disagreements instead of making them explicit.

An equal access principle, clearly stated and understood, can serve at best as an ideal toward which a society committed to equality of opportunity and equal respect for persons can strive. It does not provide a blueprint for social change, but only a moral standard by which to judge marginal changes in our present institutions of health care.

My purpose here is not only to evaluate the strongest criticisms that are addressed to the principle, ranging from libertarian arguments for more market freedom to arguments supporting a more egalitarian

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principle of health care. I also propose to examine the sorts of theoretical and practical problems that arise when one tries to defend an egalitarian principle directed at a particular set of institutions within an otherwise inequalitarian society. Since it is extremely unlikely that such a society will be transformed all at once into an egalitarian one, there ought to be room within political and philosophical argument for reasoned consideration and advocacy of "partial" distributive justice, i.e., of principles that are directed only to a particular set of social institutions and whose implementation is not likely to create complete justice even within those institutions.

The Principle Defined

A principle of equal access to health care demands that every person who shares the same type and degree of health need must be given an equally effective chance of receiving appropriate treatment of equal quality so long as that treatment is available to anyone. Stated in this way, the equal access principle does not establish whether a society must provide any particular medical treatment or health care benefit to its needy members. I shall suggest later that the level and type of provision can vary within certain reasonable boundaries according to the priorities determined by legitimate democratic procedures. The principle requires that if anyone within a society has an opportunity to receive a service or good that satisfies a health need, then everyone who shares the same type and degree of health need must be given an equally effective chance of receiving that service or good.

Since this is a principle of equal *access*, it does not guarantee equal *results*, although it probably would move our society in that direction. Discriminations in health care are permitted if they are based upon type or degree of health need, willingness of informed adults to be treated, and choices of lifestyle among the population. The equal access principle constrains the distribution of opportunities to receive health care to an egalitarian standard, but it does not determine the total level of health care available or the effects of that care (provided the care is of equal quality) upon the health of the population. Of course, even if equality in health care were defined according to an "equal health" principle (Veatch, 1976), one would still have to admit that a just health care system could not come close to producing an equally healthy population, given the unequal distribution of illness among people and our present medical knowledge.

Practical Implications

Since the equal access principle requires equality of effective opportunity to receive care, not merely equality of formal legal access, it

does not permit discriminations based upon those characteristics of people that we can reasonably assume they did not freely choose. Such characteristics include sex, race, genetic endowment, wealth, and, often, place of residence. Even in an ideal society, equally needy persons will not use the same amount or quality of health care. Their preferences and their knowledge will differ as will the skills of the providers who treat them.

A One-Class System

The most striking result of applying the equal access principle in the United States would be the creation of a one-class system of health care. Services and goods that meet health care needs would be equally available to everyone who was equally needy. As a disincentive to overuse, only small fees for service could be charged for health care, provided that charges did not prove a barrier to entry to the poorest people who were needy. A one-class system need not, of course, be a uniform system. Diversity among medical and health care services would be permissible, indeed even desirable (Starr, 1975), so long as the diversity did not create differential access along nonconsensual lines such as wealth, race, sex, or geographical location.

Equal access also places limits upon the market freedoms of some individuals, especially, but not exclusively, the richest members of society. The principle does not permit the purchase of health care to which other similarly needy people do not have effective access. The extent to which freedom of the rich must be restricted will depend upon the level of public provision for health care and the degree of income inequality. As the level of health care guaranteed to the poor decreases and the degree of income inequality increases, the equal access standard demands greater restrictions upon the market freedom of the rich. Where income and wealth are very unevenly distributed, and where the level of publicly guaranteed access is very low, the rich can use the market to buy access to health care goods unavailable to the poor, thereby undermining the effective equality of opportunity required by an equal access principle.

The restriction upon market freedoms to purchase health care under these circumstances creates a certain discomforting irony: the equal access principle permits (or is at least agnostic with respect to) the free market satisfaction of preferences for nonessential consumer goods. Thus, the rigorous implementation of equal access to health care would prevent rich people from spending their extra income for preferred medical services, if those services were not equally accessible to the poor. It would not prevent their using those same resources to purchase satisfactions in other areas—a Porsche or any other luxurious consumer good. In discussing additional problems created by

an attempt to implement a principle of equal access to health care in an otherwise inegalitarian society, I return later to consider whether advocates of equal access can avoid this irony.

Hard Cases

As with all principles, hard cases exist for the equal access principle. Without dwelling upon these cases, it is worth considering how the principle might deal with two hard but fairly common cases: therapeutic experimentation in medicine, and alternative treatments of different quality.

Each year in the United States, many potentially successful therapies are tested. Since their value has not been proved, there may be good reason to limit their use to an appropriate sample of sick experimental subjects. The equal access principle would insist that experimenters choose these subjects at random from a population of relevantly sick consenting adults. A randomized clinical trial could be advertised by public notice, and individuals who are interested might be registered and enrolled on a lottery basis. The only requirement for enrollment would be the health conditions and personal characteristics necessary for proper scientific testing.

How does one apply the principle of equal access when alternative treatments are each functionally adequate but aesthetically or socially quite disparate? Take the hypothetical case of a societal commitment to adequate dentition among adults. Replacement of carious or mobile teeth with dentures may preserve dental function at relatively minor cost. On the other hand, full mouth reconstruction, involving periodontal and endodontal treatment and capping of affected teeth, may be only marginally more effective but substantially more satisfying. The added costs for the preferred treatment are not inconsiderable. The principle would seem to demand that at equal states of dental need there be equal access to the preferred treatment. It is unclear, however, whether the satisfaction of subjective desire is equivalent to fulfillment of objective need.

In cases of alternative treatments, proponents of equal access could turn to another argument for providing access to the same treatments for all. A society that publicly provides the minimal acceptable treatment freely to all, and also permits a private market in more expensive treatments, may result in a two-class system of care. The best providers will service the richest clientele, at the risk of inadequate treatment for the poorest. Approval of a private market in alternative treatments would rest upon the empirical hypothesis that, if the publicly funded level of adequate treatment were high enough, few people would choose to short-circuit the public (i.e., equal access) sector; the small

additional free market sector would not threaten to lower the quality of services universally available.

Most cases, like the one of dentistry, are difficult to decide merely on principle. Proponents of equal access must take into account the consequences of alternative policies. But empirical knowledge alone will not decide these issues, and arguments for or against a particular policy can be entertained in a more systematic way once one exposes the values that underlie support for an equal access principle. One can then judge to what extent alternative policies satisfy these values.

Supporting Values

Advocates of equal access to health care must demonstrate why health care is different from other consumer goods, unless they are willing to support the more radical principle of equal distribution of all goods. Norman Daniels (1981a) provides one foundation for distinguishing between health care and other goods. He establishes a category of health care needs whose satisfaction provides an important condition for future opportunity. Like police protection and education, some kinds of health care goods are necessary for pursuing most other goods in life. Any theory of justice committed to equalizing opportunity ought to treat health care as a good deserving of special distributive treatment. Equal access to health care provides a necessary, although certainly not a sufficient, condition for equal opportunity in general.

A precept of egalitarian justice that physical pains of a sufficient degree be treated similarly, regardless of who experiences them, establishes another reason for singling out certain kinds of health care as special goods (Gutmann, 1980). Some health conditions cause great pain but are not linked to a serious curtailment of opportunity. The two values are, however, mutually compatible.

A theory of justice that gives priority to the value of equal respect among people might also be used to support a principle of equal access to health care. John Rawls (1971:440), for example, argues that without self-respect "nothing may seem worth doing, or if some things have value for us, we lack the will to strive for them. . . . Therefore the parties in the original position would wish to avoid at almost any cost the social conditions that undermine self-respect."

Conditions of Self-Respect

It is not easy to determine what social conditions support or undermine self-respect. One might plausibly assume that equalizing opportunity and treating similar pains similarly would be the most essential sup-

ports for equal respect within a health care system. And so, in most cases, the value of equal respect provides additional support for equal access to the same health care goods that are warranted by the values of equal opportunity and relief from pain. But at least some kinds of health care treatment not essential to equalizing opportunity or bringing equal relief from pain may be necessary to equalize respect within a society. It is conceivable that much longer waiting time, in physicians' offices or for admission to hospitals, may not affect the long-term health prospects of the poor or of blacks. But such discriminations in waiting times for an essential good probably do adversely affect the self-respect of those who systematically stand at the end of the queue.

Some of the conditions necessary for equal respect are socially relative; we must arrive at a standard of equal respect appropriate to our particular society. Universal suffrage has long been a condition for equal respect; the case for it is independent of the anticipated results of equalizing political power by granting every person one vote. More recently, equal access to health care has similarly become a condition for equal respect in our society. Most of us do not base our self-respect on the way we are treated on airplanes, even though the flight attendants regularly give preferential treatment to those traveling first class. This contrast with suffrage and health care treatment (and education and police protection) no doubt is related to the fact that these goods are much more essential to our security and opportunities in life than is airplane travel. But it is still worth considering that unequal treatment in health care, as in education, may be understood as a sign of unequal respect even where there are no discernible adverse effects on the health or education of those receiving less favored treatment. Even where a dual health care system will not produce inferior medical results for the less privileged, the value of equal respect militates against the perpetuation of such a system in our society.

Challenges

Equality of opportunity, equal efforts to relieve pain, and equal respect are the three central values providing the foundation of support for a principle of equal access to health care. Any theory of justice that gives primacy to these values (as do many liberal and egalitarian theories) will lend *prima facie* support to a health care system structured along equal access lines.

We are now in a position to consider alternative values and empirical claims that would lead someone to challenge, or reject, a principle

of equal access to health care. These challenges also enable us to elaborate further the moral and political implications of the principle.

Proponents of the Market

The most radical and vocal opposition comes from those who support a pure free market principle in health care. A foundation of support for the free market principle is the idea that the relative importance of satisfying different human desires is a purely subjective matter: we can distinguish between one person's desire for good medical care and another person's desire for a good Beaujolais only by the price they are willing to pay for each. If no goods are special because there is no way of ranking desires except by individual processes of choice, then what better way than the unconstrained market to allow us to decide among the smorgasbord of goods society has to offer (Fried, 1979; Nozick, 1974; Sade, 1971)?

Health care goods and services are likely to be more equally allocated through the market if income and wealth are more equally distributed. Several defenders of the market as a means of allocating goods and services also support a moderate degree of income redistribution on grounds of its diminishing marginal utility, or because they believe that every person has a right to a "basic minimum" (Friedman, 1962; Fried, 1978). Neither rationale for redistribution takes us very far toward a principle of equal access to health care. If one retains the basic assumption that human preferences are totally subjective, then the market remains the best way to order human priorities. Only the market appropriately decentralizes decision-making and eliminates all nonconsensual exchanges of goods and services (Fried, 1978: 124-26).

Although a minimum income floor under all individuals increases access to most goods and services, even at a higher level than that supported by Friedman and others, a guaranteed income will be inadequate to sustain the costs of a catastrophic illness. An exceptionally high guaranteed minimum might result in almost universal insurance coverage at a fairly high level. Supporters of free market allocation do not, however, press for a very high minimum for at least two reasons. They fear its effects on incentives, and they cannot justify a high guaranteed income without admitting that there are many expensive goods that are essential to all persons, and are not just mere consumer preferences.

The first reason for opposing an exceptionally high minimum is probably a good one. A principle approaching equality of income and wealth is likely to have serious disincentive effects on productive work and investment. There are also better reasons for treating health care as a special good, a good that society has an obligation to provide

equally to all its members, than there are for equally distributing most consumer goods.

A significant step beyond the pure free market principle is a position that preserves the role of the market in allocating different "packages" of health care according to consumer preferences; but concedes a role for government in supplying every adult with a "voucher" of a certain monetary value redeemable exclusively for health care goods and services. Proponents of health vouchers must assume that there is something special about health care to justify government in taxing its citizens to provide universally for these goods, and not all others. But if health care is a more important good, because it preserves life and expands opportunity, then what is the rationale for effectively limiting the demand a sick but poor person can make upon the health care system? Why should access to health care be dependent upon income or wealth at all?

Opponents of equal access generally imply that more than minimal access will unjustly curtail the freedom of citizens as taxpayers, as consumers, and as providers of health care. Let us consider separately the arguments with regard to the many citizens who are taxpayers and consumers, and the few citizens who are providers of health care.

The Charge of Paternalism

Charles Fried (1976:31) has argued that equal access to health care is a particularly intrusive form of paternalism toward citizens. He claims further that "apart from a rather general commitment to equality and, indeed, to state control of the allocation and distribution of resources, to insist on the right to health care, where that right means a right to equal access, is an anomaly. For as long as our society considers that inequalities of wealth and income are morally acceptable, . . . it is anomalous to carve out a sector like health care and say that *there* equality must reign."

Would an equal access system necessarily be intrusive or paternalistic in its operation? A national health care system simply cannot be said to take away the income entitlement of citizens, since citizens are not entitled to their gross incomes. We can determine our income entitlements only after we deduct from our gross income the amount we owe the state to support the rights of others. To the extent that the rationale of an equal access principle is redistributive, those individuals who otherwise could not afford certain health care services will experience an expansion of their freedom (if we assume an adequate level of social provision). Of course, part of the justification of a national health care system is that it would also guarantee health care coverage to people who could afford adequate health care but who

would not be prudent enough to save or to invest in insurance. Even if we accept the common definition of paternalistic actions as those that restrict an individual's liberty so as to further his or her interest, we still have to assess the assertion that this (partial) rationale for an equal access system entails a restriction of individual liberty. Unlike a law banning the sale of cigarettes or forcing people to wear seat belts, the institution of a national health care system forces no one to use it. If a majority of citizens decide that they want to be taxed in order to ensure health care for themselves, the resulting legislation could not be considered paternalistic: "Legislation requiring contributions to some cooperative scheme (such as medical care) . . . is not necessarily paternalistic, so long as its purpose is to give effect to the desires of a democratic majority, rather than simply to coerce a minority who do not want the benefits of the legislation" (Thompson, 1980:247). It is significant in this regard that for the past twenty years the Michigan survey of registered voters has found a consistent and solid majority supporting government measures designed to ensure universal access to medical care.

The charge of paternalism levied against an equal access system is therefore dubious because it is extremely difficult, if not impossible, to isolate the self-protectionist rationale from the redistributive and the democratic rationales. Those who object to a national health care system on the grounds that it is coercing some people for their own good forget that such a system still could be justified as a means to avoid the threat to a one-class system that exempting the rich would create. To condemn such a system as paternalistic would commit us to criticizing all legislation in which a democratic majority decides to protect itself against the wishes of a minority when exemption from the resulting policy would undermine it. Other critics wrongly assume that people have an entitlement to the cash equivalent of the medical care to which society grants them a right. People do not have such an entitlement because taxpayers have a right to demand that their tax dollars are spent to satisfy health needs, not to buy luxuries. Indeed, our duty to pay taxes is dependent upon the fact that certain needs of other people must be given priority over our own desires for more commodious living.

Nonetheless, two restrictions upon consumer freedom are entailed in an equal access system. One is the restriction imposed by the taxation necessary to provide all citizens, but especially the poorest, with access to health care goods. This restriction does not raise unique or particularly troublesome moral problems so long as one believes that the freedom to retain one's gross income is not an absolute right and that the resulting redistribution of income to the health care sector increases the life chances and thereby the effective freedom of many citizens.

But there is a second restriction of consumer market freedom sanctioned by the equal access principle: the limitation upon freedom to buy health care goods above the level publicly provided. Aside from reasserting the primary values of equality, there is at least one plausible argument for such a restriction. Without restricting the free market in extra health care goods, a society risks having its best medical practitioners drained into the private market sector, thereby decreasing the quality of medical care received by the majority of citizens confined to the publicly funded sector. The lower the level of public provision of health care and the less elastic the supply of physicians, the more problematic (from the perspective of the values underlying equal access) will be an additional market sector in health care.

Without an additional market sector, would the freedom of physicians and other providers to practice wherever and for whomever they choose be unduly restricted? The extent of such restrictions will also vary with the level of public provision and with the diversity of the health care system. Public funds already are crucial to providing many physicians with basic income (through Medicare and Medicaid fees), research opportunities through the National Institutes of Health (NIH), and many with hospitals and other institutions in which to practice (through the provisions of the Hill-Burton act). In place of the time and resources now directed to privately purchased add-ons, an equal access system would redirect providers toward meeting previously unserved needs. These types of redirections of supply and redistributions of demand are commonly accepted in other professions that are oriented toward satisfying an important public interest. The legal and teaching professions are analogous in this regard. The equal access principle, strictly interpreted, however, adds another restriction, a limitation upon private practice that supplies health care goods not equally accessible to the entire population of relevantly needy persons. This restriction upon the freedom of providers does not have an analogue in the present practice of law or of education, although the arguments for equal access to the goods of these professions might be similar. And so, one's assessment of the strength of the case for such a restriction is likely to have implications beyond the health care system.

It is hard to see why one ought to prevent people, rich or poor, from spending money upon health care goods while permitting them to spend money on consumer goods that are clearly not essential, and perhaps even detrimental to health. One reason might be the possible systemic effect, mentioned above, that such additional expenditures would deprive the less advantaged of the best physicians. The freedom of providers as well as consumers would have to be restricted in order to curtail this effect. But beyond this empirically contingent argument

for restricting any market in health care goods that are not equally accessible to all, the strict limitations upon market freedom in "extra" health care goods are hard to accept if one believes that medical services are at least as worthy items of expense as other consumer goods. One could argue that physicians ought to be free to meet the demand for additional medical goods, especially when that demand is a substitute for demand for less important goods.

This criticism illuminates a more general problem of attempting to equalize access to any good in an otherwise inequalitarian society. The more unequal the distribution of income and wealth within our society, the more likely that the freedom of consumers and providers to buy and sell health care outside the publicly funded sector will result in inequalities that cannot properly be regarded merely as the product of differences in consumer preferences. Therefore, in an inequalitarian society, we must live with a moral tension between granting providers the freedom to leave the publicly funded sector and achieving more equality in the satisfaction of health care needs.

A principle of equal access to health care applied within an otherwise egalitarian society might give little or no reason to restrict the freedom of providers or consumers. One argument often voiced against a publicly funded system that permits a marginal free-market sector is that the government is a less efficient provider of goods than are private parties. But the equal access principle does not require that the government directly provide medical services through, for example, a national health service. Government need only be a regulator of the use and distribution of essential health-care goods and services. This is a role that most people concede to government for many other purposes deemed essential to the welfare of all individuals.

Government regulation may, of course, be more expensive and hence less efficient than government provision of health care services of similar extent and quality. The tradeoff here would be between the additional market choice facilitated by government regulation of private providers and the decreased public cost of government provision. Despite utilitarian claims to the contrary, no simple moral calculus exists that would enable an impartial spectator to determine where the balance of advantage lies. Philosophers ought to cede to a fairly constituted democratic majority the right to decide this issue. What constitutes a fair process of democratic decision-making is an important question of procedural justice that lies beyond the scope of this paper.

Liability for Voluntary Risks?

Another important criticism of the equal access principle cuts across advocacy of the free market and government regulation of health care.

Supporters of both views might consistently ask whether it is fair to provide the same level of access for all people, including those who voluntarily adopt bad health habits, and who quite knowingly and willingly take greater-than-average risks with their lives and health. Even if it might be unjust not to provide health care for those people once the need arises, why would it not be fair to force those who choose to drink, smoke, rock climb, and skydive also to bear a greater burden of their ensuing medical costs than that borne by people who deliberately avoid these risky pursuits? An equal access principle seems to neglect the distinction between voluntary and nonvoluntary health risks in its eagerness to ensure that all people have an equal opportunity to receive appropriate health care.

Gerald Dworkin (1979) extensively and convincingly argues that it would not be unfair to force individuals to be financially liable for voluntarily undertaken health risks, but only under certain conditional assumptions. These include our ability 1) to determine the relative causal role of voluntary versus nonvoluntary factors in the genesis of illness; 2) to differentiate between purely voluntary behavior and what is nonvoluntary or compulsive; and 3) to distinguish between genetic and nongenetic predispositions to illness. For example, to satisfy the first condition one would have to determine the relative causal rôle of smoking and environmental pollution in the genesis of lung cancer; to fulfill the second, one must know when smoking (or drinking or obesity) is voluntary and when it is compulsive behavior; and to satisfy the third condition, one must distinguish among those who smoke and get cancer, and those who smoke and do not. In addition, so long as there are no good institutional mechanisms for monitoring certain risky activities or for differentiating between moderate and immoderate users of unhealthy substances, qualifying the equal access principle to take account of voluntary health risks is likely to create more unfairness rather than less. Finally, given great inequalities in income distribution, the poor will be less able to bear the consequences of their risky behavior than will the rich, creating a situation of unfairness at least as serious as the unfairness of equally distributing the burdens of health care costs between those who voluntarily impose risks upon themselves and those who do not. With respect to the health hazards of overeating and obesity, for example, the rich have recourse to expensive programs of weight control unavailable to the poor. Since we have such scanty knowledge of situations when sickness can be attributable to voluntary health risks, criticisms of the equal access principle from this perspective have more weight in principle than they do in practice.

Equal Access to All Health Goods

All criticisms considered so far are directed at the equal access principle

from a perspective suggesting that government involvement and public funding of health care would be too great and the role of the market too small in an equal access system. Now let us consider a powerful criticism of the principle for including too little, rather than too much, in the public sector. The criticism can be posed in the form of a challenge: if one crucial reason for supporting a principle of equal access is that health goods are much more essential than many other goods because they provide a basis for equalizing opportunity and relieving substantial pain, then why not require a government to provide equal access to *all* those health goods that would move a society further in the direction of equalizing opportunity and relieving pain for the physically and mentally ill? Without pretending that our society could ever arrive at a condition of absolute equality of health (or therefore strict equality of opportunity), proponents of this principle could still argue that we should move as far as possible in that direction.

In a society in which no tradeoffs had to be made between health care and other goods, equal access to *all* health goods might be the most acceptable principle of equity in health care (Veatch, 1976:127–153). Of course, we do not live in such a society. Given the advanced state of our medical and health care technology, and the prevalence of chronic degenerative diseases and mental disorders in our population, a requirement that society provide access to every known health care good would place an enormous drain upon social resources (Somers, 1971).

Costliness per se is not the main issue. The problem with the principle of equal access to all health goods is that it demands an absolute tradeoff between satisfaction of health care needs and other needs and desires. The simplest argument against this principle is that other needs, such as education, police protection, and legal aid, will be sacrificed to health care, if the principle is enforced. But this argument is too simple. A proponent of equal access to all health goods could consistently establish some priority principle among these goods, all of which satisfy needs derived in large part from a principle of equal opportunity. The weightier counterargument is that, above some less-than-maximum level in the provision of opportunity goods, it seems reasonable for people to value what, for want of a better term, one might call "quality of life" goods: cultural, recreational, noninstrumental educational goods, and even consumer amenities. A society that maximized the satisfaction of needs before it even began to provide access to "quality of life" goods would be a dismal society indeed. Most people do not want to devote their entire lives to being maximally secure and healthy. Why, then, should a society devote all of its resources to satisfying human *needs*?

Democracy and Equal Access

We need to find some principle or procedure by which to draw a line at an appropriate level of access to health care short of what is socially and technologically possible, but greater than what an unconstrained market would afford to most people, particularly to the least advantaged. I suspect that no philosophical argument can provide us with a cogent principle by which we can draw a line within the enormous group of goods that can improve health or extend the life prospects of individuals.

This problem of determining a proper level of guaranteed social satisfaction of need is not unique to health care. Something similar can be said about police protection or education in our society. Philosophers can provide reasons why police protection and education are rightly considered basic collective needs and why they should be given priority over individual consumer preferences. But no plausible philosophical principle can tell us what level of police protection or how much education a society ought to provide on an egalitarian basis.

The principle of equal access to health care establishes a criterion of distribution for whatever level of health care a society provides for any of its members. And further philosophical argument might establish some criteria by which to judge when the publicly funded level of health care was so low as to be unfair to the least advantaged, or so high as to create undue restrictions upon the ability of most people to live interesting and fulfilling lives. The remaining question of establishing a precise level of priorities among health care and other goods (at the "margin") is appropriately left to democratic decision-making. The advantage of the democratic process in determining the precise level of health care provision is that citizens have an equal and collective voice in determining a decision that, according to the equal access principle, ought to be mutually binding. Citizens not only reap the benefits; they also share the burdens of the decision to expand or limit access to health care.

There is yet another advantage to this procedural method of establishing a fair level of health care provision. If the democratic decision will be binding upon all citizens, as the equal access principle assumes it must be, then one might expect the most advantaged citizens to exercise more political pressure to increase access to health care and hence increase the opportunity of the least advantaged above the level that they could afford in a free market system, or in a system where the rich were not included within the publicly funded health care sector. One finds some evidence to support this hypothesis in comparing the relative immunity from budget cutbacks of the program under universal entitlement of Medicare compared with the income-

related Medicaid program. Of course, if costliness to the taxpayer is one's only concern, this added political pressure for health care expenditures is a liability rather than a strength of a one-class system. But from the perspective of equal access, the cost of a two-class system, one privately and one publicly funded, is an inequitable distribution of quantity and quality of care according to wealth, not need. The added nonproductive costs required merely to keep the two classes apart are seldom taken into account. And from the perspective of those supporters of an equal access principle who also want to increase the total level of health care provision, the two-class system threatens to work in the opposite direction, siphoning off the pressure of citizens who have a disproportionate share of political influence. A democratic decision, the results of which are constrained by the principle of equal access, will give a relatively accurate reading of what most people believe to be an adequate level of health care protection. The major disadvantage of the equal access constraint is that the decision of the majority or its representatives binds everyone, even those people who want more than the socially mandated level of health care.

Given the great economic inequalities of our society, it is politically impossible for advocates of equal access to fulfill their task. No democratic legislator could possibly succeed in winning support for a proposal that restricted market freedom as extensively as a strict interpretation of the equal access principle requires. And it probably would be a mistake to insist upon strict philosophical standards: one thereby risks throwing the possibility of greater access to health care for the poor out with the insistence upon curtailing access for the rich.

Conclusion

I began by arguing that a principle of equal access to health care was at best an ideal toward which our society might strive. I shall end by qualifying that statement. A sufficiently high level of public provision of health care for all citizens and a sufficiently elastic supply of health care would significantly reduce the threat to universal provision of quality health care of a private market in extra health care goods, just as a very high level of police protection and education reduces the inequalities of opportunity resulting from purchase of private bodyguards or of private school education by the rich.

In the best of all imaginable worlds of egalitarian justice, the equal access principle would be sufficiently supported by other egalitarian social and economic institutions that a market in health care would

complement rather than undercut the goals of equal respect and opportunity. But philosophers ought to resist basing their political recommendations solely upon a model of the best of all imaginable worlds.

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Access, Equity, and Equality in American Medical Care



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Basic Concepts

We begin with some basic definitions. By access we mean availability for use; a person has access to health care when he is in a position to receive it if he wishes. This implies reasonable proximity to appropriate personnel and facilities, as well as the existence of economic arrangements acceptable to all involved. Equity in access to medical care implies that medical care is available in some manner that seems fair to all involved. By equality we mean that different persons all enjoy the same access. Equity and equality are often used as though they are synonymous; they are not. Equity is not always egalitarian, and equality is not always equitable.

The concept of ideal access to medical care is useful. A person is said to have *ideal* access to medical care if he is able to receive all the care he wishes whenever and wherever he happens to be. The President of the United States has ideal access as defined here; a physician is always near, regardless of where he is. When the President travels in this country or abroad, advance arrangements have been made for his treatment in specific hospitals and by their specialists should he suddenly become ill or suffer some trauma. When President Reagan was shot, he was immediately taken to a university hospital that had all needed facilities. When President Carter earlier broke his collarbone while engaged in cross-country skiing, he was given first aid immediately and then moved by helicopter to a major government hospital. Ideal access includes swiftness of treatment and maximum convenience for the patient who is not required to wait in line for his turn, as

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ordinary mortals must. But it is worth noting that even ideal access gives no promise of immortality. Both President Reagan and Pope John Paul II would have died of their wounds if the bullets that hit them had struck vital organs. A person with ideal access can develop an incurable disease—say, glioblastoma multiforma, the most malignant form of brain tumor—and will die despite all the medical help in the world.

Under ideal conditions, all U.S. citizens would have the same access as President Reagan. This is the goal many would-be reformers seem to have had in mind in urging the adoption of universal and comprehensive national health insurance. Winston Churchill seems to have had similar ideas when, in 1944, during World War II, he held out this glowing prospect to the British people:

Disease must be attacked in the poorest or in the richest in the same way as the fire brigade will give its full assistance to the humble cottage as readily as to the most important mansion. Our policy is to create a National Health Service to assure that everybody irrespective of means, age, sex, or occupation shall have equal opportunity to benefit from the best and most up-to-date medical and allied services available.¹

Churchill's promise fell short of offering every Briton the ideal access described above. His pledge of "equal opportunity to benefit from the best and most up-to-date medical and allied services available" could be fulfilled even if Britain had only very meager modern medical facilities. Suppose it had only one heart-lung machine needed for open heart surgery. "Equal opportunity" might then mean only that a lottery was used to select the small percentage of Britons needing such surgery who would actually receive it.

If we understand that ideal access for all Americans means having available for 226 million Americans all the facilities and trained personnel needed to elevate their medical care to the presidential level, then one conclusion emerges. Neither the United States nor any other country can afford to provide ideal access for all. Just the requirement that every individual have a personal physician to accompany him everywhere would pose an insuperable obstacle. It could be met only if the entire population consisted of physicians, all paired up two by two—so that each person could have his own personal doctor always available.

Some may maintain that the above argument has carried the issue to ludicrous extremes because nobody seriously proposes giving all citizens the same access as the President en-

¹ Quoted in Paul F. Gemmill, *BRITAIN'S SEARCH FOR HEALTH*, Univ. of Pennsylvania Press, Philadelphia (1960), p. 20.

joys. Yet surely those who believe that equity means equality would deny that our reasoning is far-fetched; they might simply argue that the presidential standard of access has to be lowered drastically to a level that could be offered to all citizens. Medical egalitarianism in the United States must imply a leveling down for many people as well as a raising up for others. But it is important to understand that even a much lower level of access than presidential is expensive beyond the nation's willingness to pay. Thus, we may decide we wish to create a level of access to medical care that is based on having personnel and facilities enough to allow each 100 Americans to have their own doctor. That would be much less than ideal access, yet it would still require the availability of more than 2.26 million physicians, about 1% of the population. At present this country has only about 500,000 physicians. Yet the cost of medical care is constantly being denounced as beyond the nation's resources. Can there be any doubt the nation would reject the cost of any system based on more than quadrupling the number of doctors and the facilities they use?

We can now state the basic theorem of medical economics. This is called Powell's Law because it seems to have been first introduced by J. Enoch Powell after serving in the early 1960s as Conservative Party cabinet minister responsible for the British National Health Service. This theorem states that the potential demand for free medical care tends toward infinity. "Free" medical care is simply care paid for by somebody other than the recipient—by the government or by private insurance. When people have to pay for their own care, a prudent parsimony curbs their demands on the health care system. In a completely free system, the government or whoever else is paying the bills has to find ways of curbing demand by one or more means of rationing. Powell's Law is well understood in Britain, so it is not surprising that a British medical specialist asked some fundamental questions in a recent essay:

Can the individual be overvalued? Is there, for example, a just limit to the resources that an individual can demand to preserve him after he has developed a mortal illness? Are we right to do anything to prolong the life of a person who has become senile, demented, and incontinent? Is death always an enemy and a funeral necessarily an occasion for grief?²

The sharp point of Powell's Law is beginning to be understood in the United States, too. In 1968 when the first heart transplants were being done, the world's imagination was seized with the hope this offered. By now the usefulness of heart transplants as a modality for extending the life of people ill

² Alan Knell, *Personal View*, BRITISH MEDICAL JOURNAL, Nov. 22, 1980, p. 1420.

with heart disease has been demonstrated beyond doubt by Dr. Norman Shumway and his colleagues at Stanford University. But the cost is so high that the United States government has decided not to pay for these operations until and unless the procedure is approved after a two-year study now beginning. At the Massachusetts General Hospital it was decided that heart transplants should not be done there on the grounds that, if performed, these procedures would make impossible other types of open heart surgery now done there. In other words it was decided that what economists call the "opportunity cost"—i.e., what has to be sacrificed if heart transplants are to be done—is too high.³

There are at least three complicating factors that must be taken into account in considering access. First, what do we mean by medical care? Is it only conventional medical care or is it also any type of procedure that any American considers curative or perhaps supportive? Does access to medical care require that anyone who wants it may have a lengthy psychoanalysis? What about Christian Science and similar forms of religion-related therapy? And what about chiropractic, which, for all the lack of any scientific proof that it is effective, has many devoted patients? What of medical customs, practices, and practitioners believed in by particular cultural or ethnic subgroups of our population: the Navaho sing; the Iroquois medicine man; the Puerto Rican *curandero* who treats diseases by classifying them into "hot" and "cold" ailments, each with its own appropriate remedies; the Vietnamese practice of rubbing the body with coins; the Haitian witch doctor; the Christian faith healer typified by Ruth Carter Stapleton? It should be noted that mainstream American medicine is looking more sympathetically at some of these alternatives, not just dismissing their practitioners as quacks and confidence men.⁴ What about homeopathy, which still has adherents here and abroad? What about the newer systems of alleged therapy that have evolved out of the American cultural revolution of the 1960s, the rolfing, the iridology, the herbalism, the food faddism?

Should access to these and other alternative therapies and therapists be offered on equal footing with access to conventional medical care? People who pay their own bills can go to whom they wish. But two-thirds of the cost of American medical care is now being paid for by the government and other third-party payers. Should all alternative therapies be eligible for third-party reimbursement? If adopted, how would such a policy square with the increased practice of demanding proof of effectiveness before paying for some types of conventional care?

³Harry Schwartz, *How Much is a Life Worth?* WALL STREET JOURNAL, Sept. 15, 1980.

⁴Morgan Martin, *Native American Medicine*, JAMA, Jan. 9, 1981, p. 143.

A second complication is that of deciding when and if a given individual needs medical care. Should a patient have access to care whenever he wants it, or should access be limited to those who have objective signs of illness? When I served in the United States Army infantry during World War II, it was automatically assumed that a soldier turning out for sick call was a malingerer unless and until he had proved the contrary. The proof might be a fever, the discharge of blood from some body orifice, abnormal blood or urine chemistry, or the like. But in ordinary medical practice, every physician knows that many patients come with complaints of one type or another, but no objective signs of illness. Some call these people the "worried well"; others speak of hypochondriacs. There is no problem when patients pay their own bills. But for how much of this allegedly imaginary illness should the government and other third-party payers foot the bill?

A third complication is that demand for medical care is often for very specific care. A patient who has broken her leg needs very different care and facilities than one who has burns over much of his body.

Patients, regardless of ailment, want to be treated near their homes to minimize inconvenience for themselves and their families. Hence patients want well-equipped hospitals near where they live. But the third-party payers want to regionalize care to minimize the number of hospitals, especially hospitals with costly high-technology equipment such as CAT-scanners. The resentment against such regionalization becomes apparent when one tries to close down an unnecessary hospital. Then one sees demonstrations, political pressure, and other signs that the community wants convenience, not economy. Moreover, the local residents who have jobs at the threatened hospital or who sell its goods and services have very good economic reasons for opposing any rationalization of the system.

Access and Utilization

Our discussion indicates that all existing systems give imperfect access to medical care. No large community can provide all its members access to all the medical care they might want, unrestrained by cost. Rational discussion must focus on what kind and what degree of imperfections may be more or less acceptable than others. Since no Utopia is possible, every advocate of major change in an existing system of access is really urging replacement of one set of imperfections by another set—or of improving the access of one group of people at the expense of another group, unless one is prepared to increase the amount of real resources being devoted to medical care. But today sentiment is strong to cap the real volume of resources going to medical care.

If we turn now to the question of how access and utilization have changed in this country, the evidence is unmistakable that a vast and positive revolution has taken place. Official government data show that in 1964 poor Americans averaged 3.9 visits to physicians against 4.8 for nonpoor Americans. In 1978, the picture was reversed with poor people averaging 5.6 visits and the nonpoor 4.7 visits. This same revolutionary change is shown in the relationship of race and physician visits. In 1978 the average numbers of visits by poor whites and nonwhites (5.7 and 5.6 respectively) were far higher than those of nonpoor Americans of all races.⁵ By 1978, the data indicate, access to physician services in the United States no longer depended seriously on one's income or on the color of one's skin. It is a sad tribute to the continuing power of stereotypes over people's minds that it is still widely believed in this country that the poor have much inferior access to physicians than the nonpoor. Similar trends are apparent if we look changes in hospital utilization. In 1977, families of less than \$5,000 income received 1541 days of hospital care as against 678.9 days of hospital care for families with incomes of \$25,000 or more. In that same year, black families averaged 1354.9 days of care against 962.9 days of care for white families.⁶

The outstanding conclusion from any objective examination of the abundant available data is that access to and utilization of medical care in the United States has been more nearly equal and equitable in recent years than ever before in American history. This does not mean that there cannot of course be improvements. But the widely cultivated myth that medical care in this country, is somehow reserved only for the rich is precisely that, a myth.

What Made the Progress Possible?

What made the improvements noted above—especially the sharp improvements for disadvantaged groups—possible?

The introduction of Medicare and Medicaid must certainly loom large in any explanation. The two programs removed many of the financial barriers that had hindered many poor people, particularly the elderly poor, from obtaining all the medical care they wanted. Of course, Medicare also covered the nonpoor elderly. Medicaid, whose coverage varies among the states and whose cost is shared between Washington and the states, has turned out to be a complex series of programs that

⁵National Center for Health Statistics, HEALTH UNITED STATES 1980, Dept. of Health and Human Services, U.S. Government Printing Office, Washington, (1980), p. 68.

⁶National Center for Health Statistics, HEALTH UNITED STATES 1979, Dept. of Health and Human Services, U.S. Government Printing Office, Washington (1979), p. 199.

has aroused much criticism. Thus, Medicaid's rapidly rising costs produced consternation in many states that had not been at all prepared for the bills that needed to be paid. Frantic efforts at economy, sought through limiting coverage and cutting or holding down fees to physicians and hospitals, have produced numerous complaints from those affected. It is now universally acknowledged that Medicaid is plagued with much abuse and waste by both beneficiaries and providers. Many physicians throughout the country refuse to see Medicaid patients because fees paid them are low, sometimes inadequate to meet even their overhead cost. Nevertheless, Medicare and Medicaid served to greatly increase use of the medical system by the old and the poor. Also, since the political pledge was to put the old and the poor in the mainstream of American medicine, both programs served to stimulate hospital purchase and installation of the latest high-technology equipment. Similarly, both programs encouraged growth of the system of specialists and subspecialists, formerly used mainly only by the well-to-do but access to whom was now deemed also a right of all people covered by third-party payers. All these forces helped propel upward the access, utilization, and cost of medical care. In turn, government officials of both parties struggled to moderate costs by increasingly severe regulation, by backing utilization review and health facilities planning, and—most recently in the Reagan administration—by urging a cap on Medicaid expenditures and by proposing a reorganization of American medical care that would encourage competition.

The rapid increase in physicians in the United States has also played a key role both in increasing access to medical care and increasing the cost of this care. In 1965 the United States had about 300,000 doctors. Now, the corresponding figure is roughly 500,000, an increase of about two-thirds. But the United States population over that same period increased by little more than 15%, or only about one-fourth as rapidly. In 1965 the United States had roughly 1 physician for every 650 people. In 1980 the corresponding ratio was about 1 physician for every 450 people.⁷ The rapid rise in the number of physicians was made possible in part because of the sharp increase in the number of American medical schools and in the average size of their classes. In 1980 these schools graduated about twice as many physicians as in 1965. Additionally, in the 1960s and 1970s large numbers of foreign-trained physicians, most of them from Asian countries, were admitted to this country on a preferential basis to ease what was officially labeled the "doctor shortage." But by the end of the 1970s both Democratic and Republican officials began urging a slowdown in the training and admission of new physicians as one means of slowing down the rapid increase in medical care costs.

⁷HEALTH UNITED STATES 1980, *supra* note 5, p. 47.

The British Experience

Earlier we quoted Winston Churchill's promise of "equal opportunity to benefit from the best and most up-to-date medical and allied services available." Britain's National Health Service (NHS) has now been in existence more than 30 years, but both equality and adequacy of access to medical are unrealized dreams.

Originally, back in the 1940s, British officials responsible for the NHS thought that demand for medical care would increase for a time and then decline. Problems neglected earlier would have to be repaired, they forecast, but then people would be healthy and demand would decline. Reality soon showed this forecast to be fantasy, as demand for medical care mounted ceaselessly.

British officials sought to meet the demand by emphasizing the existence of a large group of general practitioners throughout the country to whom, in theory, patients have access 24 hours a day. But even today GP coverage is not uniform throughout the country, and complaints of difficulty of access are heard particularly in the inner cities and in the more remote regions of Scotland. The GP does make house-calls, but he provides a rather limited service. By American standards he has only rudimentary equipment (often only a stethoscope), and normally he spends only a very few minutes with each patient. He does not give anything like an annual physical examination. Many GPs seek to control the demand for "free" use of their services by requiring patients to make appointments in advance. But then their secretaries are often accused of trying to discourage patients who call for appointments.

The key to British medical economics is the extensive effort that has been made for many years to limit the number of hospitals, hospital beds, and top hospital specialists. The result is that every Briton needing NHS specialist care or hospital treatment must—except in the most urgent emergencies—wait for his turn in a queue. In England alone the number of persons awaiting hospital admission rose from 460,000 at the end of 1949 to more than 600,000 at the end of 1977. Many patients are awaiting admission for elective surgery: hernia repairs, hemorrhoid operations, hip replacements and the like, all procedures that can improve the quality of life of the recipients. But the need for many to wait a year or two or longer for such operations tends to make life more miserable. In Britain the rationing method used to cope with Powell's Law is simply forcing people to wait and wait and wait. Some people die while waiting, thus terminating their demand.

In 1976, during a visit to London, I spent an hour speaking to the admissions officer of St. Thomas's Hospital, one of London's newest and best-equipped hospitals. The admissions

officer told me that about 5000 people were waiting for admission, but that most of them would never get in. Persons applying for admission, I was told, are ranked by urgency of need. First-priority applicants are those classified as "urgent," and these can usually be admitted within six months of application. An "urgent" case might be an individual who had reported visible blood in his urine. But one special class of "urgent" patients had been singled out for especially prompt treatment, I was told: Women who reported lumps in their breasts were normally admitted within one month.

Precisely because of this need for waiting and queueing, private medical care is still alive in Britain. The Harley Street specialist in London still does very well. And many patients are hospitalized as private patients, either in the growing number of private hospitals being built in Britain or in the "private beds" of NHS hospitals. The last Labor Government sought to eliminate the latter "private beds," but suffered electoral defeat before it could complete the task. Private medical insurance organizations are increasing in membership, not least because more unions are becoming interested in obtaining access to private care for their members. In furious response to this unexpected turn of events, the radicals now in control of the British Labor Party have indicated their intention to eliminate all private medicine in Britain when and if the Labor Party again rules the country. But the recent split in the British Labor Party makes the outlook for its return to power uncertain indeed, and meanwhile the increasing reluctance of Britons to put up with the delays and queues in the National Health Service is producing changes whose final result no one can foretell. What is clear is that the present British Conservative Government is happily encouraging the spread of private medical care as a means of somewhat reducing the demand for and the burden on the "free" NHS.

Nevertheless, the vast majority of Britons have to make do with the NHS, and many of them are well aware of the glaring inequalities of medical resources—and therefore of access—among different parts of the country. A major program was begun several years ago to implement the recommendations of the Resource Allocation Working Party (RAWP), aimed at narrowing the differentials by transferring resources to the worst-supplied areas. London is the best-supplied area, and the city is the medical as well as the political and economic capital of Britain. Not surprisingly, many medical and non-medical people in London have effectively opposed the RAWP program, arguing that even London is not adequately supplied with all needed medical resources and hence should not be deprived in any way.

A few figures will illustrate the inequalities of medical personnel in Britain. Within England itself, the number of GPs

per 100,000 population varied in 1977 from a low of 45.2 in the Trent area to almost 55 in the Northwest Thames area (part of London). In Scotland the number was 59.4 GPs per 100,000. A similar pattern is visible with respect to consultants, or medical and surgical specialists. Within England, there were 16.6 consultants per 100,000 persons in Trent and 25.8 in Northwest Thames. In Scotland, the comparable figure was 31.2.⁸ In its May 9, 1981, issue, the *BRITISH MEDICAL JOURNAL* gave the picture for cardiologists. England and Wales, it pointed out, had 1 cardiologist for every 220,000, while Western European nations have two to ten times more cardiologists relative to population. Within England, it showed the familiar glaring inequalities. The Wessex region had two full-time cardiologists for over 2.5 million people, but the Northwest Thames area had 27 cardiologists for 3.5 million people. So much for Churchill's wartime promise.

Decisionmaking Criteria

All possible medical systems are imperfect, we have seen. It is in their decisions about how to share the deficiencies that societies reveal their attitudes toward equity and equality. Let us look at the spectrum of possibilities.

Worth. Society may apportion access to medical care in some rough proportionality to the implied worth or assumed contribution of different persons. The individual's worth may be measured by financial position, rung on the ruling Communist Party power ladder, or some other criterion. Equity here is derived from the measure of worth, and even gross inequality can be justified on the basis that there are gross inequalities in how much different individuals contribute. Yet such societies tend to have a minimum available to all.

Equal Availability. To some people equity and equality are synonymous, though they are in fact not. Such people argue that equity requires equal availability of medical care to all. One version of what they may have in mind may be illustrated by a community with, say, 1 million inhabitants and \$5 million available for medical care in a given period. Equity and equality here might mean having exactly \$5 worth of medical care available to each citizen.

The defects of this simplest system of medical rationing are easily visible. In any given period most people are relatively healthy and need little if any medical attention. A minority of people are very sick and need a great deal of medical attention. Thus, the equal distribution of available resources to people with very unequal needs means many people are entitled to

⁸Data are from the Office of Health Economics, *COMPENDIUM OF HEALTH STATISTICS*, 3rd edition U.S. Government Printing Office, Washington (1979). The data are for 1977.

care they don't need and may not even want, while people at the other extreme of need predictably receive far less than required.

A more sophisticated variant of such rationing might seek equity in equality of access over an individual's lifetime—rather than in any limited period such as a year or even a decade. Thus, assuming fixed prices for all medical care, it might be decided that every individual is entitled to a maximum lifetime allotment of, say, \$100,000 worth of care, which he may distribute over time as he wishes. But one person may be very healthy all his life and then die at age 46 in an airplane crash that kills him immediately. He may use only 5% or 10% of his lifetime allotment. Another individual may be born with an open spinal column (*spina bifida*) and other serious abnormalities. He may require surgery and intensive care from the first minutes after his birth. By age 2 he may already have consumed his allotted lifetime total of \$100,000 worth of medical care. To preserve this view of equity, must he be left without further care?

Need. An alternative is to decide that equity lies in giving each person access to the medical system in proportion to that individual's need. But who decides need, the individual or society? If we give the individual unlimited access to all the care he thinks he needs, we are up against the problem forecast by Powell's law. Hence, society must decide need and set priorities. Who should have priority, a 2-year-old with leukemia or a 75-year-old woman with kidney failure? How much psychiatric care shall be allotted to neurotics and how much to psychotics? Why help the old, if there are babies or children whose medical needs are unmet? Why give hemophiliacs the Factor 8 powder they need to prevent hemorrhages if this will permit them to attain maturity and reproduce, thus guaranteeing the birth of more hemophiliacs? If the problem of tissue rejection is solved, shall we permit heart transplants for all who want them, or limit transplants by age or other criteria? How much resources should be allocated to autistic children, victims of Down's Syndrome, and the profoundly retarded?

Conclusion

We could continue in this vein, but the point seems clear enough. Once we recognize that all needs cannot be met by unlimited care, we are forced into an agonizing process of trying to give priorities to different needs, each more heart-breaking than the next. *THE LANCET*, in its March 14, 1981, issue deplores the fact that many kidney disease sufferers die in England because of the inadequate supply of dialysis equipment. It reports that a patient's chance of being put on dialysis is twice as great in London as in Northwest England. How did the doctors concerned deal with the moral and ethical prob-

lems of this situation? The magazine reports that "5 out of 9 directors of renal units interviewed did not admit to any short-fall in available places. Each claimed that he was not rejecting any referred patient who was medically suitable for treatment. In other words, a process of rationalization had occurred in which medical indications were unconsciously determined by medical resources." Medical needs under the system discussed in this alternative are ultimately decided by the economic resources available to meet them. And since resources will be inadequate by definition, some portion of the population will have to die or suffer even though technical means to prevent either outcome are known.

We conclude that in medical care any generally acceptable form of equity is unattainable. And it is certainly not attainable by trying to achieve equity through any precise form of equal allocation.

Access To Health Care

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Access to health care is an extremely complicated subject whose many facets are sometimes difficult to understand. Our common language does not ensure mutual understanding. Consequently, when health care issues are discussed, an endless debate often begins on basic language differences. The process of understanding is further complicated when individuals and groups whose philosophies and agendas are almost diametrically opposed use similar or identical language to express their programs and proposals.

To understand what is meant by access to health care, it is necessary to understand the relationship between health care, the quality of life, and societal responsibility. Despite a common language, communication is difficult between individuals and groups when background, culture, education, race, religion, and experience are different. In some learned circles the differences between medical care and health care are considered critical. In other equally learned circles the significant differences are minimal and may be a matter of degree of the same amorphous, ill-defined, yet highly fractionated and specialized body of services.

Health is the usual objective of health care. Hospice care and many other forms of health care fit this usual objective of health care imperfectly. Death may be defined as the complete absence of health. By this logic, health is essential to life. Avoiding theological concerns with eternal life, one seeks to define health.

Health is a state of complete physical, mental, and social well being and not merely the absence of disease or infirmity. Enjoyment of the highest attainable standard of

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health is one of the fundamental rights of every human being without distinction of race, religion, political belief, or economic and social condition.¹

Most of the nations of the world have subscribed to these principles from the constitution of the World Health Organization.

Article 25 (1) of the Universal Declaration of Human Rights adopted by the United Nations General Assembly in December, 1948, states:

Everyone has the right to a standard of living adequate for the well-being of himself and of his family, including food, clothing, housing, and medical care and necessary social services and the right to security in the event of unemployment, sickness, disability, widowhood, old age, or other lack of livelihood in circumstances beyond his control.²

"The opportunity to enjoy optimal health through access to needed health services has become recognized in recent years as a basic human right," said Dr. Marvin Bostin in the introduction to his doctoral dissertation.

In commenting on the World Health Organization's constitution and Article 25 of the Universal Declaration of Human Rights, Dr. Bostin said: "While the exercise of individual responsibility through effort and decision is vital to the attainment and maintenance of health, society must adopt measures which guarantee to all citizens equal opportunity to make meaningful decisions in respect to their health. Responsibility for health thus involves government at all levels as well as the individual citizen."³

Society and Equal Access

It is clear that vested interest groups, nongovernmental organizations, and corporations must operate in a manner that will assure the best interest of the whole society. If the society is to survive, it must protect itself against those individuals and organizations whose activities are regularly against the best interests of society. It should be recognized that an unjust society is a sick society whose eventual demise is certain.

Society must assure equal access by all to comprehensive health services of high quality at a cost all can afford. The

¹ World Health Organization, *Constitution*, in *CHRONICLES OF THE WORLD HEALTH ORGANIZATION*, vol. 1, pp. 29-43 (1947).

² Konvitz, Milton, *Bill of Rights Reader*, p. 5 (Ithaca: Cornell University, 1954).

³ Bostin, Marvin J., *CIVIL RIGHTS AND THE ADMINISTRATION OF VOLUNTARY HOSPITAL SERVICES*, chapter 1 (New York University thesis, February 1972).

function of good government is to protect and to promote the best interests of society. Although all levels of government must be appropriately involved in the guaranteeing of the right of access to health and medical services, the ultimate government responsibility must rest with the Federal government.

Our nation's greatest asset is a healthy people. Therefore the Federal government must take the lead and initiative in planning and promoting the development of health resources. Since each of the 50 states and various territories is different in many ways (often reflected in governmental variations and procedures rooted in local traditions and laws), the task of health care assurance is difficult. Our modern society is so mobile that state lines are almost obliterated. Multi-state residence is for many of our citizens a fact of life.

Only through Federal action and local cooperation can the opportunity for health care among the people of the various states be equalized. To the extent that state or local action, government or voluntary, falls short of safeguarding the health of the people, the Federal government must be prepared to act to meet the need in a forthright and effective way.

The involvement of the Federal government in health care and societal welfare increased its tempo on March 4, 1933, at the start of the first administration of President Franklin Delano Roosevelt. Today the role of the Federal government is a major role. However, further definition is needed.

The current standard of equal access to federally aided health services and facilities developed in stages through a combination of court decisions, legislation, and affirmative actions by the executive branch of the Federal government. The principle of equality under Federal programs was reflected in presidential actions long before the Civil Rights Act of 1964 became law.

The President's Commission on the Health Needs of the Nation was created by the Executive Order of President Harry Truman in December 1951 for the purpose of evaluating, among other things, "the degree to which existing and planned medical facilities, such as hospitals and clinics, meet present and prospective needs for such facilities," and "the extent of federal, state, and local government services in the health field, and the desirable level of expenditures for such purposes." In its report to the President, the Commission stated:

The maintenance of health must now be added to food, shelter, and clothing as one of the necessities of living . . . national neglect of proper measures for the preservation of health exposes the country to weakness and destruction . . . we believe that . . . access to the means for the attainment and preservation of health is a basic human right . . .

(and) . . . the same high quality of health services should be available to all people equally.⁴

Defining Access

Although I agree with those who have contributed to an understanding of access, I will try to define it more precisely as it is used with health care.

Webster's NEW WORLD DICTIONARY OF THE AMERICAN LANGUAGE gives two definitions that I think are relative to the content of this paper. I will use these two along with others as I try to explain what is meant by access to health care: *A way or means of approach, and the right to come into, approach, or use; admittance.* I think these are the more acceptable definitions of access and express the understanding of many people. However, in the health industry the meanings of many words have been altered and usage has changed, leading too often to increasing confusion. A recent U.S. president made the classic comment that the language was inoperative.

Many of the members of the Madison Avenue advertising industry use the language in nontraditional or unconventional ways. Some of the companies selling private health insurance succeeded, without breaking the letter of the law, in deceiving patients about the extent of their health care coverage. An example is the private health insurance policy that proclaims complete and comprehensive coverage for everything in bold print on the first page of the policy contract. The exclusions and exemptions are listed in fine print on the next 26 or so pages, which are seldom read and understood by the unsuspecting patient (purchaser) who usually does not really plan to be sick (that's for other people).

Within the usual limitations of language I define "access to health care" as the freedom from barriers to health care. A barrier is anything that constrains, deters, delays, denies, dissuades, discourages, handicaps, or prevents the acquisition or utilization of those services that are ultimately provided by society to its members individually and collectively for maintenance, preservation, and improvement of health. Dying a dignified death in comfortable surroundings can be enclosed in this definition, since life is finite.

Access Barriers

In the United States access problems involve large segments of our population. Some of the subsequent discourse will

⁴ President's Commission on the Health Needs of the Nation, *BUILDING AMERICA'S HEALTH*, vol. 1, pp. 1-3 (Washington: U.S. Government Printing Office, 1953).

generate some understanding, if not agreement, with the position I have taken. For too many Americans, quality health care is a dream deferred. Their access is limited.

Poverty and Race. It is ironic that among the major industrialized countries in the world, only two, the United State of America and South Africa, have failed to develop a national health insurance system or a national health service to more nearly ensure that quality health care is available to all their residents. The U.S. leads the world in per capita income and expends more per person for personal health services than does any other nation. In the face of these facts, it is shocking to review the health statistics and realize just how much illness and untimely death is suffered by the poor in the United States.

Many volumes have been written about the correlation between poverty and ill health. It is a true statement that "the sick get poorer and the poor get sicker." In 1967 the U.S. Department of Health, Education, and Welfare issued a publication, *THE DELIVERY OF HEALTH SERVICES TO THE POOR*, which continued the documentation of this phenomenon observed over many years.

Working literally in the shadow of the Columbia University Presbyterian Medical Center, the late Edward Suchman studied some of the social correlates of medical deprivation. The observations he made during his study of health attitudes of a diverse ethnic population in Washington Heights, New York City, during 1960-61 would probably be reinforced by a follow-up study done today. Dr. Suchman found that lower-income families who were highly ethnocentric, or who restricted social experiences to members of their own group, had an unfavorable attitude about medical care. The study further showed that the stronger the degree of ethnocentricity, the more unfavorable the attitude was likely to be about medical care.⁵

Ethnic minority groups tend to reinforce negative impressions and perceptions toward health providers on the basis of prevailing community attitudes, particularly in lower socioeconomic regions. In many black communities a high incidence of disease may be directly related to the unconscious reluctance to seek early treatment because it is purveyed by non-black health providers.

In New York City, for example, since the 1966 implementation of Medicaid we have seen the growth of the shared health facility frequently called the "Medicaid Mill." Simultaneously, we have seen a sharp decrease in the number of physicians engaged in the solo practice of medicine in less affluent communities.

⁵ Edward Suchman, *Social Factors in Medical Deprivation*, *AMERICAN JOURNAL OF PUBLIC HEALTH* 55, 11, pp. 1725-1733. (November 1965).

In direct relationship with low Medicaid reimbursement rates we see a declining number of physicians who are willing to serve Medicaid patients in private offices. The result is that Medicaid patients are being driven back to clinics in numbers that exceed the pre-Medicaid days. This is a serious perversion of the intent of the legislators who enacted title 19 of the Social Security Amendments of 1965. The estimates of the numbers of physicians who refuse to see significant numbers of Medicaid patients in "private" offices run as high as 97% in New York City.

The "working poor" are people who earn too much money to be eligible for Medicaid and not enough money to buy insurance to pay for their medical care.

The third-party reimbursement rates for clinics and for hospital-based ambulatory care have failed to keep pace with the rapidly escalating cost of medical care. Ambulatory care deficits have increased. Hospitals have been forced to reduce or curtail their services to the poor. Many hospitals have been forced to move to affluent communities or to go out of business, as larger numbers of medically indigent, underinsured patients, and uninsured patients are forced to seek care in these institutions that remain in the inner-city areas.

The Federal government, through the Department of Health and Human Services (DHHS), has designated certain areas that have been seriously damaged by loss of providers and facilities as medically underserved areas (MUAs). These distressed areas should enjoy a high-priority role in the reconstruction of our cities and towns.

It is a frequent observation that some inner-city problems are aggravated rather than solved by some of the solutions. Urban renewal in too many instances is tantamount to removal of poor and minority persons.

Access to quality health care is reduced by virtue of residence in a poor neighborhood. Many different studies have documented the synergism between poverty and ill health. The incidence of illness as evidenced by morbidity and mortality statistics is, almost without exception, higher in these federally designated Medically Underserved Areas of our urban communities. Rural areas of affluence are usually better off, in spite of a reduced number of health care providers, than are the less affluent rural communities.

Physician Maldistribution. The out-migration of the population to the suburbs has been directly associated with a similar out-migration of hospitals, physicians, and other health providers. However, it should be noted that urban areas of affluence have not suffered these losses. In fact, there has been a significant increase in facilities, physicians, and other health providers in many affluent urban areas. The concentration of these

health providers is particularly marked in places like Beverly Hills, California, the North Shore of Long Island (Nassau and Suffolk counties), and the fashionable East Side of Manhattan along Fifth, Madison, and Park Avenues—where physicians, hospitals, medical schools, and other health providers are concentrated, and at times are so contiguous as to be sardonically referred to as “Bedpan Alley.”

A 1977 survey in New York City by the City Department of Health showed the following:

(1) Health Planning Area 18 in the Tremont section of the South Bronx had a population of about 10,000 and not 1 private physician available.

(2) Health Planning Area 59 in the Morrisania section of the Bronx also had the same size population and also had no private physicians.

(3) Health Planning Area 20 in the Bedford Stuyvesant section of Brooklyn had a population of 19,000 and only 1 practicing private physician.

(4) Health Planning Area 29 in the Brownsville section of Brooklyn had 22,000 residents and only 1 private physician.

(5) The preceding areas were populated by low-income black and Hispanic families.

Meanwhile, in the affluent East Side of Manhattan in the heart of Bedpan Alley, one health planning area between 79th and 96th Streets had a population of 32,000 people and 1089 practicing private physicians. The relationship between poverty and illness is once again highlighted by the infant mortality rates. The Bronx area had a rate of 24.2 and 28.7 per 1000 babies (male and female rates, respectively). The Brooklyn areas had 24.9 and 28.0 per 1000. On the East Side the rate was 11.1 and 16.9 per 1000 babies. Morbidity and mortality increase when the physician supply decreases.

The Graduate Medical Education National Advisory Committee (GMENAC) predicts a high excess of doctors by the year 2000, with a surplus of 130,000. GMENAC recommends that no new medical school should be established. No increase in entering classes should be permitted. There should be a decrease of 10% in the number of medical students by 1984. The continued expansion in the production of physician assistants and nurse practitioners should be halted because of the danger of a glutted health provider market.

GMENAC is typical of much that is wrong with our health care delivery system. It is limited in scope and vision and threatens to do much more harm than good. I like to call GMENAC the Physician's Protective and Exclusion Program of the 1980s. It seems to be designed simply to prevent the development of an abundant supply of physicians in the future. One

of my principal criticisms of GMENAC is the timid approach it makes toward confronting the problem of physician maldistribution. The American College of Surgeons is especially critical of GMENAC and seriously challenges its assumptions, its methodologies, and its conclusions.

Race/sex/nationality factors. The problems of access have significant implications for minority physicians and other health providers. The rise in the cost of a medical education has serious implications for health professionals drawn from the ranks of the poor. Minorities, including black and Hispanic persons, are seriously underrepresented in the ranks of physicians. Blacks today make up something less than 2% of the physician population of the United States. Not just coincidentally, women are less than 12% of the physician population. In many of the nations of the world the majority of the physicians are female. This is particularly true in the larger socialistic countries such as the People's Republic of China and the Soviet Union.

There is added significance to these facts when one realizes that in the U.S. women are responsible for more than 60% of the physician/patient contacts. The American white male still completely dominates the medical profession, although there has recently developed a tremendous dependence on foreign-trained M.D.s (FMGs) to supply our health manpower needs. For example, recently nearly 55% of the physicians who were first licensed to practice in New York received their M.D. degree from a foreign medical school. Nationwide it was 30%. The importation of foreign M.D.s will undoubtedly continue until legal and regulatory restrictions are imposed on this practice or until health care delivery systems are restructured to the extent that our dependence on the FMG is curtailed. There is loose talk in high places about a physician surplus. Unless the health care delivery system is changed, with manpower being distributed according to demographic and medical need, nothing could be farther from the truth. It is true that a more equitable method of distributing health manpower could perhaps reduce the demand for physicians. But such is not the case today.

There is an incestuous relationship between poverty and ill health. There is no such relationship between health manpower and ill health. Manpower tends to follow the money; physicians tend to congregate where there is money, abandoning less affluent neighborhoods. Here too, racism is superimposed on the problems of the poor.

Physicians may abandon poor neighborhoods and areas inhabited by racial minorities because they are afraid of bodily harm or loss of property (personal or professional), or because they can make more money in more affluent neighborhoods, or because they want to avoid the societal stigma and loss of prestige (social and professional) that results from association

with minorities, or because most upper middle-class whites are latent racists. The question can be argued for a long time without final definition. It is a fact that those areas where our nation's ethnic minorities reside are nearly devoid of physicians and health facilities. It is just as clear that the manpower distribution does not adequately serve the needs of ethnic and less affluent minorities. It is the majority belief among blacks that the health care delivery system is racist.

One survey of welfare families found that 70% of blacks and 35% of whites felt their physicians were rude. More than 72% of the blacks and more than 46% of the whites agreed that doctors were prejudiced against people on welfare. And 67% of the blacks thought that doctors were prejudiced against them.

The contempt for the poor is clearly a learned response on the part of most physicians, who are taught on clinic patients and perfect their skills on these so-called second-class citizens. Once the skills are perfected, the physician then feels that he is good enough and absolutely free to sell his skills in more affluent areas, which are called "private." In the eyes of too many physicians the more affluent are more worthy of deferential treatment than are the poor. In our materialistic society the poor are thought by many to have had an equal opportunity and to have failed.

The poor are not homogenous, often having only their poverty in common. Stanford Roman points out:

When we use "community" as an organizing principle, we begin to see how much is distorted and overlooked when we lump people of different communities into convenient socio-economic categories. We see that a policy that attempts to increase utilization only by lowering costs may fail short of its goal if other issues relevant to the community are not simultaneously addressed. Politically, the stratification of health issues along income lines has given rise to poverty issues that are equated by some of the public with charity issues. Even members within a community may be lulled into believing that they are not underserved because they are not poor, yet remain underserved because they are elderly, members of a racial minority, or women. Efforts to change the care for the poor may be perceived by the poor themselves as charity. A major effort to involve the poor in the process of decision making was a part of President Lyndon Johnson's War on Poverty. In the area of health as well as in community organizations, maximum feasible participation of the poor was mandated. Community participation was embodied in Public Law 89-749, the Comprehensive Health Planning Act of 1966 (CHPA). In many parts of the nation the implementation of Public Law 94-641, the Health Systems Agencies (HSA) Health Planning and Training Act of 1976 was a direct outgrowth of the community activity and experience gained in the CHPA.

The Great Society of Lyndon Johnson was nullified because of the Vietnam War; and business as usual continued during the Nixon-Ford administration, due in large part to the community disorganization that resulted from the power struggle between the diverse elements of the community, (new black middle class vs. poor blacks, etc.) For blacks, the government policy was a malignant policy of benign neglect that allowed communities, in fact entire inner cities, to deteriorate insofar as jobs, housing, education, goods, and services were concerned. The monolithic requirement implied in the too-often-asked question, "Who speaks for the community?" was used as a basis for disastrous community neglect.

The Need for a National Health Policy

Historically, however, the health care system has reflected the needs and desires of the more affluent group members. Both health professionals and government have often shared this concern, to the disservice of the poor and to the total society. The response of the health industry has always been to the dominant economic element of our society. The most important element of the new health care delivery system is people and this can be a direct reflection of a new national health policy. This policy should reflect concerns that are more broadly representative of the majority of the people and communities in which they reside, rather than being responsive only to the economic elite—the corporate population that makes up our ruling class (less than 3% of the total population). Since most government actions have some economic impact, they usually reflect the desires of the elite. However, the health system is a labor-intense industry and it is largely dependent on the interaction between human beings. It can and does reflect individual prejudices and preferences. It can reflect institutional racism with uncanny accuracy. It does not have to, but it often does.

Roman says:

that if we are to substantially improve these services, we must train more individuals sensitive to these underserved communities, we must begin to develop organizations of care that reflect these community biases rather than the norms of the suburbs, we must encourage participation of community interests in the decision making processes not only at the local level but at the national level. Policy makers must begin to recognize that our nation is not a melting pot, but a bowl of stew. No policy which neglects the differences between people will be effective. The lack of or absence of a national health policy makes rational and coordinated health planning difficult, if not impossible.

Douglas A Fraser, President of the International Union, United Automobile, Aerospace, and Agricultural Implement Workers of America, lists the following causes of our health care crisis:

- (1) absence of a national health policy,
- (2) runaway health care costs,
- (3) lack of access,
- (4) fragmental organization of services,
- (5) inadequate quality of care, and
- (6) failure of the private insurance industry.

I would add as (7) the failure of some of the government health insurance programs. Success in solving the health care crisis is contingent upon resolving the underlying causes of our present failures.

Referring to lack of access, Fraser continues,

Significant portions of our population, particularly low-income workers, the poor, the ethnic minorities and those who live in the urban ghettos and rural areas, find it virtually impossible to get decent health care when they need it. Nearly 51 million Americans, typically those with limited resources and usually the most needs, live in areas without sufficient health services. Seeking care is often delayed to the point of being fatal and the few medical services that are received are often provided in such demeaning settings as hospital clinics, emergency rooms and Medicaid Mills. Millions of other Americans cannot get adequate care even if they have basic health insurance coverage. Having money in pocket to buy medical care does not necessarily mean it is available. It does not assure access nor assure that what is available is appropriate.⁶

He demonstrates quite adequately the relationship of the absence of a national health policy to our health problems.

There is an absence of priorities in our health program. Other industrialized nations, such as Canada, the United Kingdom and the Scandinavian countries, have clearly defined goals with explicit plans for achieving their objectives. They have a national health policy set in relation to their respective national health programs. We, on the other hand, have some two dozen federal health care programs and dozens more at the state and local levels which more often than not conflict. We spend large sums of money to

⁶ Goodman, Raymond, *Proposal for a National Health Policy*, pp. 8-14, in PROCEEDINGS, National Health Forum, Schools of Medicine and Public Health, University of Southern California at Los Angeles, March 10, 1979.

detect a single health problem and yet do almost nothing to help individuals find the funds to enable him or her to secure the good care which may be available. We provide funds for some to purchase care but do little to see that care is available. We permit providers to operate as free market entrepreneurs. But consumers are faced by a controlled market where they must pay the charges and receive the services in a manner set by solo practice doctors, hospitals and nursing homes.⁷

Those who tell us that we cannot afford to take the necessary steps to improve our delivery system and thus assure equity of access to all of our citizens are usually those who monopolize or disproportionately command a large share of the health care delivery system. These staunch defenders of the status quo resist change and resent those whose honest moral convictions lead them to advocate the change. It is necessary that we correct the flaws in "the traditional methods of medical practice."

Additionally, with rising unemployment and runaway inflation, increasing numbers of people are losing their access to health services.

Legislative remedies developed within the context of a sound national health policy would help us move to a solution of our most critical health problems—either lack of access to health care or inadequate access to health services.

Fraser suggested the following principles on which a meaningful national health policy could be built.

- (1) All economic barriers to care must be removed. We must provide for a single universal national health insurance program covering the entire population regardless of age, race, income, employment or unemployment status.

- (2) Fully paid health benefits should be available to cover the entire range of personal health services including the prevention and early detection of disease. Good health care to be effective must consist of much more than the treatment of acute episodic illnesses. Such comprehensive coverage would help close that gap between what we know about health care and the care we actually receive.

- (3) Incentives must be built-in to make possible the delivery of more efficient, high quality health services. There is substantial evidence to demonstrate that non-profit health maintenance organizations (HMOs) provide more and better care at less cost. In 1978 persons covered by the Blues and the commercial insurance companies used 1022 hospital days per 1000 people. The HMOs nationally used 408

⁷ *Ibid.*

days per 1000 people. A national health policy should use its leverage to practice teamwork health care delivery through HMOs, outpatient primary care centers and other innovative organizational forms. These groups could be reimbursed on a capitation basis for enrolled groups, thus encouraging them to maintain health rather than treat illness.

(4) Financing of health services should be simple and equitable. Strict budgeting and cost control measures should be implemented. Hospitals and doctors should be paid negotiated amounts based on annual budgets with caps determined in advances. Physicians should be entitled to reasonable fees within pre-determined national and regional ceilings. Hospitals should be required to present prospective budgets relating both to their own services and to other hospitals in the same area so that duplication of expensive and underutilized services could more effectively be controlled.

(5) Effective health planning and allocation of resources must be tied to a financing mechanism that provided the necessary leverage and support to bring about reform. Consolidation of hospital services and high-cost medical technologies would make better use of existing resources, reduce waste and excessive profits, and literally save billions of dollars.

(6) Scrutiny of quality of care must be an integral part of our national health policy. Once and for all we must eliminate unnecessary surgery and laboratory tests and the inappropriate utilization of esoteric medical technologies which our present system permits and which occur with alarming frequency.

(7) Consumers must be assured a role at every administrative and decision making level. The time has passed when the patient can and will accept blindly what he is told is good for him. Health care policies only become meaningful and relevant when those who pay for and use services play a role in determining the policies. There must be provider risk sharing. Presently the consumer takes all the risks. Those who provide health care services must be directly accountable to those who pay for them.

(8) A carefully structured national health plan with regional administration should replace the present chaos of federal, state and local programs and private insurance companies selling different policies and administering them with thousands of different and often conflicting benefit packages, guidelines, and procedures. Such a plan could, for the first time, make possible the planning, budget procedures, and cost controls so desperately required.

(9) Incentives should be included to overcome the shortage and maldistribution of health personnel. Funds must be made available to train and upgrade personnel in those services that are in short supply. Coupled with this over-all national health policy, we must develop programs to control the introduction and proliferation of new health care technologies and, at the same time, order our medical and other scientific research activities in relation to consumer and societal needs.

These are principles upon which to base a national health policy. The list is by no means all inclusive. But, I submit to you that to make real gains those principles must be tied to a comprehensive national health insurance program. We often hear the claim that those of us who support a comprehensive approach to reform are looking for a pie-in-the-sky free lunch. They acknowledge the problems in health care to which I allude, but they suggest that we try to get them fixed one by one. They tell us that we should not try to do it all at once.

But a piece-meal health policy will not shore up our collapsing health care system. Incrementalism has been the approach which we have followed in this country for the last 30 years. It is precisely this philosophy which has led us to this deplorable state of affairs in health care today. Only if we adopt a comprehensive national health policy which will generate real reforms in the organization, delivery and financing of health services, can we preserve the best in our present system and replace its worst features. If we continue with a piece-meal approach, the whole system will continue to disintegrate.⁸

Increasing Primary Care Physicians. Fear, justified or unreasonable, is a barrier to health care. Access to health care is limited by many psychological barriers that prevent the establishment of a rapport between patients and providers of care. When the compensation for a given service is perceived by many providers as being low or inadequate, a judgment may be made by the provider that the patient is of less worth. The distinctions between clinic patients and private patients are very real and may affect the quality of the care and the outcome as well.

Most medical students and physicians in training perfect their skills on clinic patients. Experimental procedures and clinical investigations are performed, often without informed consent, on these second-class patients. In most instances, the private or first-class patients are not routinely used for teaching purposes. In spite of the tremendous increase in tax dollar

⁸ *Ibid.*

support for the health professionals, the poor are still forced to barter their bodies for care of sometimes doubtful quality.

When physicians have perfected their skills and their training is complete, then they are free to sell those skills to the highest bidder or even to withhold services. The physician is then certified by a specialty board; this automatically enables him/her to charge higher fees for complex procedures as well as for simple, routine procedures. The physician is also free to move to whatever community he/she wishes. Large numbers of physicians are usually found in affluent areas as compared with the scarcity in poorer areas.

The Health Professionals Education Assistance Act of 1976 (P.L. 94-484) declared that "There is no longer an insufficient number of physicians and surgeons in the United States," while acknowledging that many areas in the U.S. have inadequate numbers of health professionals to meet their health care needs and that physician specialization has resulted in inadequate numbers of health professionals, and that physician specialization has resulted in inadequate numbers of primary care physicians.

The AMA, as well as the Coordinating Council of Medical Education (CCME), have urged that least 50% of all American medical school graduates enter residency training in primary care specialties. In 1977, 65% of medical school graduates began graduate medical education programs in the primary care specialties of family practice, general practice, internal medicine, pediatrics, and obstetrics and gynecology. The impact of these residents on the availability of primary care services will not be felt until they complete their graduate education.

From 1969-70 to 1976-77, the number of primary care residency positions (family practice, general practice, internal medicine, obstetrics and gynecology and pediatrics) increased from 14,532 to 30,692, an 111% increase. Positions filled in the programs grew from 12,053 to 29,309—143%. This increase was due in large part to the fact that the medical profession since the mid-1960s has promoted the development of primary care and the desirability of more graduates seeking careers in these specialties. Bolstered by recent Federal legislative incentives, there is every reason to believe this trend, which was in place prior to the Health Professions Educational Assistance Act of 1976, will continue.⁹

Physicians are now beginning to establish practices in small affluent communities and may thereby serve some rural

⁹ American Medical Association, *Medical Backgrounder*, MEDICAL MANPOWER, p. 2, July 1979.

affluent populations not previously served proximally to their residences. These phenomena have resulted from a recent increase in the emphasis on primary care. This is a sad paradox because, as I previously stated, inner-city areas are still losing providers and facilities at an alarming rate. These inner-city areas federally designated as medically underserved areas continue to expand in size, and their medical problems intensify accordingly.

The American Academy of Family Physicians has studied closely the distribution and function of graduates of family practice residency programs. As of July 1, 1977 there were 3,394 graduates of modern accredited residency programs in family practice. 75-80% of each graduating class has located in communities of 100,000 or less and over 50% has located in communities of 30,000 or less. These statistics provide preliminary evidence that physicians educated in modern family practice residency programs will locate in substantial numbers in relatively small communities where their services appear to be needed particularly at this time.

There has been remarkable growth in modern family practice residence programs from essentially a zero base in 1969 to 325 accredited programs by mid-1977. The number of first-year residents increased from 0 to 2,043 while the total number of residents went from 0 to 5,421. The appeal of the residency programs to medical graduates is evidenced by a 94% fill rate in the 1977 first year positions.

In the period from 1969 to 1977, over 80% of the U.S. medical school developed departments or divisions of family practice, where virtually none existed previously.¹⁰

Limiting Foreign Medical Graduates. Access to health care is limited by language and cultural barriers. Foreign medical graduates are a broad-spectrum species and, like American medical college graduates, range from excellent to the opposite. In some instances their training and clinical experience have been inadequate by American medical college standards. Those whose skill and training are judged to be less than excellent are forced to choose the less desirable training facilities and to find employment at less desirable jobs. In poor sections of Brooklyn in 1980, one municipal hospital failed to attract a single American medical college graduate and depended on a house staff comprised of 97% foreign medical graduates. Many of these physicians had serious problems with English and required the frequent assistance of interpreters. The situation is further aggravated by the low level of education of those patients whose primary language was neither English nor the primary language of the physician. It is presently estimated that across the United

¹⁰ *Ibid.*, p. 3.

States 25% of the physician work force is composed of foreign medical graduates. In the major cities of the United States, particularly those cities with large numbers of poor people, the concentration of foreign medical graduates seems to be greater, although foreign medical graduates are found in community hospitals in every state. In spite of problems of training, language and culture, in many instances there are few or no alternatives to hiring foreign medical graduates. It is clear that proposed legislation and recently enacted legislation will affect different communities in different ways. It seems certain that adverse effects will be felt initially in the less affluent communities.

The number of Foreign Medical Graduates (FMG) being trained and practicing in the United States will decrease sharply as a result of P.L. 94-484, which restricted FMG entry into the country. The number of FMG's, by origin of medical education, serving in residencies in the U.S. reached a peak of 19,221 in 1973. As of December 31, 1977, the number had decreased to 10,188—a 33% decline from the previous years. The decrease was most striking for first year residents, from 2,805 in 1976 to 600 in 1977.

In 1973 over two-fifths of physicians receiving their initial licenses were graduates of foreign medical schools (7,419 of 16,689). By 1977 the number was reduced to less than one-third—5,851 of 18,175.¹¹

Strengthen Affirmative Action Programs. Since 1975, there has been a decline in the percentage of blacks in medical schools. "This decline may be due in part to the growing cost of medical education and expanded opportunities for minorities in other careers. First year enrollment of other nonwhites (Asian, Commonwealth Puerto Ricans and other Hispanic students) rose slightly from 4.3% in 1977-78 to 4.7% in 1978-79. Foreign nationals continued to represent less than 2% of first year enrollments."¹²

The expanded opportunities, in my opinion, are illusory. The applicant pool for opportunities has been kept low by the denial of access to quality education at every level. The quality of public education in many cases has been sabotaged or allowed to deteriorate, and funding for private education for nonwhites has been minimal from all sources.

Access to health care is limited by racial prejudice. Blacks, Hispanics, and other racial groups are significantly underrepresented in the medical profession. A survey conducted by the Urban League in 1942 revealed that only 14 hospitals in the United States permitted the black physician to receive training

¹¹ *Ibid.*, p. 4.

¹² *Ibid.*

leading to a specialty status. Further, the survey showed that a total of 85 black physicians in the entire United States were board-certified. The total number of black physicians in the U.S. is currently estimated at 9000-10,000.

Between 1971-72 and 1978-79, the first-year enrollment of black Americans increased numerically, but declined proportionately: In 1971 the total was 882 (7.1%); in 1978 the total was 1061 (6.4%). Enrollment for other minorities has increased both numerically and proportionately: For American Indians, Mexican-Americans, and mainland Puerto Ricans, the increases were from 181 (1.5%) in 1971-72 to 382 (2.3%) in 1978-79. Those minority group targeted for increased representation in U.S. medical schools (blacks, Native Americans, and mainland Puerto Ricans) amounted to 8.7% of the first-year class in 1978-79, compared with 9.0% in 1977-78.

The drop-out rate for minority students is about twice the national average, and the admission rate has now dropped sharply; this is reflected in the lag in production of black physicians. Foreign medical graduates count few American blacks in their numbers. The decline in admissions has been aided by the assault on affirmative action programs by DeFunes, Bakke, and others. These actions threaten to completely wipe out the rather minute progress that appeared to be made from 1970 to 1980. The magnitude of the continuing problem is underscored by the fact that black physicians today make up less than 2% of the physician population of the U.S.

Just as during the days of reconstruction, the racist movement is gaining momentum in its efforts to reverse the black gains through the elimination of affirmative action programs in all aspects of American life. Although Allan Bakke was rejected by more than a dozen medical schools and by some of them for several successive years, he chose to attempt to legally maintain the advantage that he, as a white, had gained through more than 350 years of racial discrimination—by attempting to destroy a token affirmative action program: A program designed not to decrease the number of white physicians produced (because medical school classes have generally increased far in excess of the number of black students admitted under any circumstances), but to insure that, now and in the future, minority students would be admitted. The emotion-charged battle cry of the exposed racist is “reverse discrimination.”

Historical Legacies for U.S. Health Care

Racism. Racism is a senseless, hostile assault on the minds, bodies and souls of the victims. White racism, morbid and destructive, which led to the institution of black slavery, was given a carte blanche when, in the Dred Scott case, the U.S.

Supreme Court stated that blacks had no rights that whites were bound to respect. The high court did a further disservice to the nation when it declared racial separation to be legal (*Plessy vs. Ferguson*). It accepted the separate but equal rights doctrine, knowing full well its intent was to discriminate against blacks in quality and quantity of resources provided.

If a minority individual, particularly a black, is to survive in a hostile society, he or she has to strike a balance between the realities of life in America with the induced cynicism and the dreams and aspirations that are necessary for survival. To set one's goals too high is to ensure frustration and defeat. But not to set goals high enough is to accept mediocrity without a noble struggle.

The black in America experiences a life filled with paradoxes. Racial repression is felt to some degree by almost every identifiable black. Yet average white Americans, even the so-called experts on race relations, have little understanding of the psychological pressure exerted on blacks by a society whose traditions are interwoven with racism. A liberal is only a person who deviates from the so-called normal patterns of racism. Race riots preceded and followed the Civil War. However, they intensified, and destroyed white-owned property rather than just black lives in association with the civil rights movements of the 1960s. It is little more than a decade since the National Advisory Commission, as it is popularly known, was appointed (July 1967) and issued its report (February 29, 1968). It made many prophetic statements.

Our nation is moving toward two societies; one black, one white, separate and unequal.

What white Americans have never fully understood but what the Negro can never forget, is that white society is deeply implicated in the ghetto. White institutions created it, white institutions maintain it and white society condones it.

The conclusion was not unanimously accepted, and the report was condemned by many, including Richard Nixon, who was then campaigning for the presidency.

On April 4, 1968, Dr. Martin Luther King, Jr., was murdered. New waves of even more severe riots were set off. From 1965 to 1969, when the disorders began to taper off, about 250 people had been killed, 12,000 injured, and about 85,000 arrested. Property damage was estimated at several hundred million dollars.

The deterioration of the ghetto (neighborhoods abandoned, vandalized, burned) has continued and intensified. Polls suggest that blacks still trapped in the inner city are more hopeless and helpless than ever. Yet many whites feel that too much has been done for minorities. The "second battle of Bunker Hill" in

Boston (1975-1977) saw white adults attacking black children, visitors to historic monuments. The presence of blacks brought bigots to the streets in scores of northern cities, while integration proceeded in many parts of the South with genuine human concern.

In 1619 when Jamestown was settled, most of the blacks, like many of the whites, arrived as indentured servants. Those pioneer blacks had little reason to believe that this land of great freedom and promise was being populated by a people who would destroy the Native Americans and would condemn those black brothers and sisters who survived the "middle passage" to perpetual slavery. The institution of slavery condemned the children of slaves and their descendents to lifelong slavery, leaving a legacy of eternal misery to unborn generations.

Class struggles. Slavery was different things to different people. Above all else, however, slavery was an economic institution that held captive a source of cheap black labor. When emancipation finally came, the greatest threat to freedom posed was to the poor whites because of their potential threat to the economic stability of the lower-class whites. The economic class struggle fanned the fires of racism and kept poor whites pitted against poor blacks. One of the tragedies of this struggle was the failure to develop a tradition of quality health care for all.

And this class struggle goes on even today. We are all affected by the race and class struggle and its many ramifications. Organized religions have contributed very little to the solution of the race problem. It has perhaps made the oppressed and the oppressors more tolerant of the status quo with promises of change, "in the sweet by and by," or "golden slippers in heaven." On earth, sectarian hospitals and health care institutions were developed to care for special segments of the population.

There are few physicians practicing in the United States today who have not benefited from the class system that encourages a dual or multiple health care delivery system—in which the bodies of the poor are practice objects used for the perfection of medical skills.

Robert E. Dawson, M.D., immediate past president of the National Medical Association speaking for the organization on the subject of unequal access to health care, had this to say:

[A]s the National Medical Association, we face not one patient, but many. As an association of black physicians, we are particularly aware of the unequal status of Black Americans with regard to health care. We know that the figures on infant mortality rates, teenage pregnancies, and life expectancy tables all prove that black men, women and children are not given equal access to health care with other Americans.

As a society of professionals we must act to end that inequity. Last year I promised to carry your concern to the men and women who plan our health care systems. I did so. To my surprise, I found that they are beginning to listen. But alas, they did not hear. Most sections of proposals for national health care programs are still unacceptable. I also found that planners and regulators of health care are not malicious or people of ill will. I am also convinced they know what the problems are, and precisely what we mean. In fact, a member of the White House staff outlined a section of the problem so beautifully one wondered if he could have had sickle cell anemia. We find John Smedley, B.S., M.S., Ph.D., a health care planner who is alert, resourceful, intelligent, and even caring at times. But he, like others, frequently is blinded by the industrial model for planning. Listen briefly to health care planner Smedley in action: "This area," says Smedley to his board, while looking at a map of the inner city, "is losing population. Since we no longer need these beds, we'll move them to our hospital over here, where the population is growing." Planner Smedley does not notice that the people left behind are those who can least afford to seek a doctor across town, or in the suburbs. He fails to see that some are too old to leave the area. If Smedley notices these facts, he rejects them. If we open the new hospital, he is saying that we are serving 90% of the population.

Smedley is a victim of what we call the "industrial model." If you design a machine that is guaranteed to produce all perfect widgets, the cost is \$200,000 per machine. But Smedley says, "I can get a \$125,000 machine that produces 9 perfect widgets out of 10. At a \$2.00 profit per widget, I can break even and pay for the \$200,000 machine that makes 100,000 perfect widgets. However, with the \$125,000 machine, I can sell the 90,000 perfect widgets at the same \$2.00 profit and make \$180,000, \$55,000 more than the \$125,000 I paid for the cheaper machine. "See," says Smedley, "Isn't that better?"

"What about the 10,000 bad widgets, Smedley?"

"Oh, we can set up a department to handle complaints and we could recycle some of them."

The National Medical Association will have to tell health care planners that this cost-benefit analysis does not work with people. We must teach Smedley how to share our professionalism. We cannot, as physicians, accept a health care system which automatically, without question, treats ten percent of the population or even one percent, as waste material.¹³

¹³ Dawson, Robert M., JOURNAL OF THE NATIONAL MEDICAL ASSOCIATION 73, NOVEMBER 1, 1981.

Solutions

Better Prenatal, Perinatal, and Postnatal Programs. For many groups the lack of access is directly related to the categorical and restrictive approaches to the problems of special individuals and groups. A recent statement by the Committee to Improve Black Pregnancy Outcome provides us with some interesting insights into the problem. The statement which follows also reveals some of the reasons why our piecemeal approach to the problem is inadequate.

The infant mortality rate in the U.S. has been declining steadily during the past 25 years, but the disparity for Black infants still persists. (1) In 1977, the latest year for which nation-wide infant mortality data by race was available, data indicated that for Black infants the mortality rate was nearly twice that of whites (a rate of 23.6 deaths per 1,000 live births). This data further identified the leading threats to Black infant survival as: (1) little or no prenatal care during the early stages of pregnancy; (2) congenital disorders; (3) low-birth weight and premature births; and (4) substance abuse during pregnancy. (2) The Supreme Court's recent ruling under *Harris vs McRae*, which upheld the Hyde Amendment to cut Medicaid funded abortions for poor women, may result in increased Black infant mortality rates. This ruling may contribute to a higher number of teenage pregnancies, and back alley abortions, which would further endanger the lives of the mother and fetus.¹⁴

On June 30, 1980, Senator Cranston, Chairman of the Subcommittee on Child and Human Development, held an oversight hearing on "Efforts to Reduce Mortality and to Improve Pregnancy Outcome." At this hearing, a number of witnesses and child health interest groups identified the need for a Department of Health and Human Services (HHS) to coordinate and expand existing maternal and child health programs to improve black pregnancy outcome. In addition, this hearing indicated that the problem of black infant mortality was related to existing problems in the health care delivery system, characterized by: inadequate planning for maternal and child health services; fragmentation of health resources affecting inner city and rural areas; lack of skilled health manpower, and effects of the Hyde Amendment, which may prevent the nation from achieving the national goal for lowering infant mortality to 9.0 per 1,000 live births by 1990.

The Medicaid Program was enacted under Title 19 of the Social Security Act to provide access to comprehensive main-

¹⁴ Committee to Improve Black Pregnancy Outcome, THE POLICY DILEMMA OF REGIONAL PERINATAL DEVELOPMENT: THE CASE OF BLACK INFANT MORTALITY.

stream medical care for the poor. However, many poor female health consumers still do not have access to comprehensive medical care (e.g., prenatal care), due to gaps in Medicaid coverage, eligibility criteria, and benefits. In addition, many states sometimes deny reimbursement for services to a newborn whose family may have a low enough income but has not yet enrolled the newborn infant under Medicaid.

The above-outlined problems have increased for mothers who are covered under Medicaid. Since Medicaid-eligible newborns are not automatically covered at birth, the mother must apply for the infant at the office of eligibility determination. In those instances where the family does not promptly apply for Medicaid coverage of the newborn, the physician and hospital may not be reimbursed for the services they provide. This phenomenon has discouraged some physicians from serving Medicaid-eligible newborns, and it has imposed financial distress on inner-city and rural hospitals that provide services to infants without health insurance coverage.

The introduction of the Child Health Assurance Act (H.R. 4963) in the 96th Congress is viewed as the major child health initiative of the last decade to improve accessibility services for infants, children, and adolescents. DHHS's improved Child Health (ICH) initiative has helped to target additional maternal and child health funds to those health services areas with poor maternal and infant health status. This approach has been successful in a number of urban areas, including: (1) Newark, New Jersey's program to increase community health centers and availability of prenatal care; (2) Oakland, California's Perinatal Systems Development Program to increase health education support and bonding services, and the designation of a Level III Perinatal Center for high-risk pregnancies; and (3) District of Columbia's Mayor's Blue Ribbon Task Force on Infant Mortality, which expanded prenatal care and developed an ambulatory care system involving hospital transport and intensive-care units. Each of these strategies was supported by an increase in Federal and state maternal and child health (Title 5) funds to reduce black infant mortality rates in targeted catchment areas. These efforts reveal the need for a more comprehensive and systematic approach to improve the structure, planning, and management of maternal and child health services.¹⁵

A Regional Perinatal Systems Development Program to help coordinate existing maternal and child health services (Titles 5 and 19 of the Social Security Act) is clearly desirable in minority communities to effect parity of black infant health status in medically underserved areas. A Perinatal Systems Development Program can be successful if it meets these requirements:

¹⁵ See: Bostin, *supra* note 3.

(1) Increases the availability of quality obstetrical services by increasing the number of physicians, physician assistants, nurse practitioners, and certified nurse midwives in medically underserved areas.

(2) Emphasizes prenatal and infant care services targeted to communities with poor health status indicators and high teenage pregnancy rates.

(3) Improves reimbursement for child services under Title 19.

(4) Coordinates increases case management efforts for child health services under a regionalization approach.

(5) Encourages support and bonding measures.

(6) Increases child health service planning by Health Systems Agencies.

(7) Improves health promotion and outreach activities.

(8) Designates inner-city Level 2 Perinatal Centers for high-risk pregnancies.

The major issue is to what extent the nation will begin to place a high priority on the black infant mortality problem in an effort to reform the health care delivery system. Since existing maternal and child health services are not well planned and coordinated, pregnancy outcome in medically underserved areas will continue to be poor. Consequently, a greater commitment to Perinatal Systems Development is viewed as an important aspect in resolving high-risk black pregnancies.

Effective health planning principles are needed to assist maternal and child health managers to target increased perinatal services in those communities with the highest rates of diabetes, hypertension, teenage pregnancy, and various kinds of malnutrition that may prevent a safe pregnancy for both mother and fetus. Early identification of health problems through prenatal care and nutrition screening is a critical factor to improve black infant morbidity and mortality status in the future.¹⁶

Recruit More Women Physicians. Access to health care has been limited by sexism. Traditionally in the United State, the white American male has dominated the medical profession. It was not until the feminist movement was reignited by the civil rights movement of the 1960s that it began to demand equal

¹⁶ See: U.S. Department of Health and Human Services, *DISEASE PROMOTION AND HEALTH PROMOTION; FEDERAL PROGRAMS AND PROSPECTS*, p. 38 (Washington: Government Printing Office, 1978); George Lythcott, statement before the Senate Committee on Labor and Human Resources, Subcommittee on Child and Human Development, June 30, 1980; Gregory Ahart, statement before the Senate Committee on Labor and Human Resources, Subcommittee on Child and Human Development, June 30, 1980; Jerry Weaver, *Policy Responses to Complex Issues: The Case of Black Infant Mortality*, *JOURNAL OF HEALTH POLITICS, POLICY AND LAW*, Spring 1976.

rights for women in medicine. The success of the feminist movement has been dramatic; nevertheless the situation for women in medicine is still far from satisfactory.

The number of women in the entering class of medical schools increased from 786 (8.9%) in 1964-65 to 4162 (25.2%) in 1978-79. In 1978-79 the proportion of women students varied from 15% or less at four schools to 35% or more at nine institutions.

Improve Access for the Elderly. The elderly as a class have been hit hard by inflation in the cost of health care. Medicare, since its inception, has covered a decreasing percentage of the health care expenses of the elderly. During the period of 1970-79 the Consumer Price Index rose 87% for all items, while charges for Medicaid services rose 200%.

In 1978, medical bills for persons aged 65 and over averaged \$2026 per capita, compared with \$764 for those aged 19-64 and \$286 for those under age 19. In 1981, the per capita expenditure for persons 65 and over may exceed \$3000. A national expenditure for personal care in 1981 of \$250 billion would represent 10% of the Gross National Product (GNP). As recently as 1975 the expenditure for personal health services represented 8.3% of the GNP. In 1950 the percentage of the GNP expended for personal care was 4.6%.

For the elderly individual on a limited or fixed income, out-of-pocket medical expenses appear to be increasing at a frightening rate. On January 1, 1981, Medicare required that the individual recipient of Medicare must pay the first \$180 of any hospital stay. This is a \$20 increase from the charges in 1980. If the hospital stay goes beyond 60 days, the Medicare recipient must pay \$45 a day, which is an increase of \$5 over the year before; this increase applies through the 90th day. If the stay goes beyond 90 days the recipient must pay \$90 a day (up from \$80 the year before) for the extent of his 60-day lifetime reserve. If, after three days in the hospital, the recipient is moved to a skilled nursing facility, his full coverage will last for 20 days. After this, and until the 100th day, the recipient must pay \$22.50 per day, \$2.50 more than the 1980 rate.

Many elderly individuals find that their "golden years" are uncomfortably enmeshed in unanticipated poverty. The lack of access to the necessities of life is becoming a fact of life for too many of our senior citizens. This painful situation is only partially relieved by charity, welfare, and Medicaid. This state of dependency is not a just reward for a life of hard work and sacrifice.

Conclusion

Our government must set policy that will increase access to dignity and self-respect for all of our citizens. This is not a

utopian goal. If our nation is to survive, it must reorder its priorities so that the materialism of a few will not destroy the humanity of the many.

It is clear that there is a significant disassociation between the need for care and the utilization of care. Since health care in the United States is frequently most available to the affluent (regardless of need), similarly the highest-quality care—including the concern for privacy and the consideration of human dignity—is most often available to the more affluent. The poor often seem less worthy.

Barriers to health care are less formidable for the rich. To the extent that physicians control the utilization of health services, we have already seen that more services tend to be provided when it is certain that money is available to pay for the services. Although patients are usually not the cause of the overutilization of health services, they are frequently cited as causative agents.

Teaching institutions generate problems because of their focus on the education of the students. This primary focus tends to reduce the status of the patient to that of "teaching material." Since private patients are frequently off-limits to students, overutilization of laboratory studies and diagnostic facilities in this situation is clearly the responsibility of the teacher rather than the patient.

However, access to the teaching institution is now related to reimbursement as much as it is to teaching functions. It is sometimes necessary to remind medical educators that education in our health care system should be a means to an end rather than an end in itself. A clear national health policy would help to maintain this focus. It is of interest to note that there are teaching institutions that obliterate all distinctions between patients, including both source of payment and source of referral, in order to afford a greater measure of equity and dignity to all. Clinic or "second-class" patients are thereby relieved to a large extent, of the stigma of being considered merely "teaching material."

Without settling the debate on the cause and extent of overutilization, it is important to remember that most medical services beyond the initial contact or first visit, are ordered by the physician.

It is quite clear that the health status of the population improves, in most instances, with increased access to health care. There are qualified exceptions, such as excessive or unnecessary surgery performed primarily for profit. However, prenatal, perinatal, and postnatal care followed appropriately by good pediatric care make a significant difference in infant and maternal morbidity and mortality. When these services are provided it is easy to measure the true value of preventive medicine.

Access to health care alone cannot overcome the adverse effects of ignorance, poor housing, hazardous employment, polluted air and water, etc. However, it can do much to prevent mental retardation, sickle cell anemia, rickets, and cretinism. The early detection of cancer in many cases has a life-or-death impact on the outcome. The controlled diabetic does not suffer the disastrous complications to the extent that the uncontrolled diabetic suffers them. Worldwide access to a little health care (smallpox vaccination) has eliminated a dread disease as a clinical entity. Although diphtheria is seldom seen today, a recent diphtheria outbreak in San Antonio, Texas, was most severe among those families whose access to health care had been sharply limited.

It is time to bring reality to the promise of health care as a fundamental right. It is hollow rhetoric unless steps are taken to transform our national care system (or nonsystem) into one that bestows a meaningful measure of equity on all of our people. To fail to take the necessary steps, access being a first step, is cruel and myopic. A healthy people is the expected result of a health policy of which our nation can be proud. A healthy people is a national asset, one that can be measured in terms of productivity. But more importantly, it can be measured in the improvement in quality of life.

Where there is a widespread perception of inequality and lack of equity, the individual's motives and actions tend to become self-centered, thereby depreciating and diminishing concerns for society as a whole. Where there is advantage there is also disadvantage. Where individuals and groups profit excessively at the expense of the society, the society, if it is to survive, must protect itself from this counterproductive and ultimately destructive activity.

Physicians and other health care providers are licensed by the society they are privileged to serve. Society maintains the right to revoke the license and to deny this privilege to those whose activities are detrimental to the best interest of the society. The U.S. has made, and continues to make, tremendous financial investments in its health care industry. It is imprudent not to get a better return on our investments.

The governmental programs of the past 25 years have been responsible for significant changes in access. It is because of Title 6 of the Civil Rights Act of 1964 that Federal dollars have impacted directly on access to health care. The creation of the Office of Equal Health Opportunity within the Public Health Service did more than any other single program. Its impact was felt most directly by hospitals as they were attempting to prepare for the implementation of Titles 18 and 19 of the Social Security Amendments of 1965. Hospitals were forced to end discriminatory practices based on race if they were to be certified to receive Federal funds for these programs. In the space of three months, thousands of hospitals that had denied access

to minorities or had discriminated against them either ceased or markedly decreased their overt practices. Title 18 gave increased access to those over 65 years of age; and Title 19, with individual state enactment and implementation, gave increased access to the very poor.

The Office of Economic Opportunity developed, among other activities, a neighborhood health center program in urban and rural areas; this afforded the opportunity for maximum feasible participation of the poor. Access was improved. Employment of neighborhood people changed the expectation of the poor, and upward mobility became a possibility for many for the very first time.

Regional medical programs for heart disease, cancer, stroke, and related diseases increased communication and provided ways in which primary, secondary, and tertiary care could be improved. Access to advanced technology was improved.

The adverse effect of the "separate but equal" clause of the Hill-Burton Hospital Construction Act of 1946 has persisted until the present time. The full measure of service that was promised by most of the hospital recipients of these Federal dollars has never been delivered. The discriminatory patterns and practices of this piece of legislation are largely responsible for much of the maldistribution of hospitals and providers that troubles our health care industry today. The malignant effects of the denial of access to blacks and to the poor will remain in our morbidity and mortality statistics for many years to come.

Categorical programs have frequently increased access for certain patients. Hypertension, sickle cell disease, children and youth and numerous other programs legislated over the past 20 years have had mixed effects on access to health services in general.

With the expectation that our nation will be spending our money at the end of the 1990s at a rate exceeding \$768 billion annually, we cannot afford to have large segments of our population denied access to health care. It is incumbent on government to assure access to health care for all of our citizens just as it is available for the President, the Members of Congress, and the armed forces.

Vale, pero millones de veces mas, la vida de un solo ser humano, que todas las propiedades del hombre mas rico de la tierra.

(It is worth millions of times more, the life of a single human being, than all the riches of the wealthiest man on earth.)

—Traditional Spanish Proverb

Philosophical Perspectives on Access to Health Care: An Introduction

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Daniel Wikler, Ph.D.*

The Philosophical Approach

The President's Commission was charged with reporting to Congress on the ethical implications of differences in the availability of health care. The Commission, in keeping with its nature as a body addressing ethical questions, has interpreted this mandate as demanding an assessment of the moral adequacy of existing patterns of access to medical care. Thus, the Commission took on two distinct tasks: First, to determine the actual, current patterns of access to medical care; second, to arrive at an ethical standard for access to care to which the present system might be compared.

The first, empirical task required a compilation of survey and research findings on health care needs and resources. The Commission's report demonstrates that health care in recent years has become available to many more Americans than ever before, but that a gap remains. Health insurance has been a major factor in increasing access to health care; yet, despite the trend toward universal coverage, many millions have no insurance. This number grows when unemployment spreads, causing loss of job-related health benefits. And those who are covered by health insurance sometimes face limitations on benefits, so that each individual does not receive adequate health care. Many other factors, such as race, age, distance, time, and travel costs, also continue to affect the availability of health care.

The empirical data, then, show limits to present-day access on both persons covered and benefits received. How should

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these limits be evaluated from the moral point of view? Few will insist that the only morally satisfactory health care systems are those that provide all possible kinds of care to all who might benefit. There is no such system in the world, and there probably never can be. Once it is accepted that even the best health care system will be limited in scope, however, ethical judgment must admit of complexity. We cannot be content merely to call for an approximation of the ideal, for health care tends to be delivered in quanta rather than in degrees: People either have health care or they do not. Near-universal coverage still leaves some people with no coverage at all. Nearly comprehensive benefits still fail to provide precisely the kind of care needed by the unlucky patient whose condition calls for services omitted from the package of benefits.

What, then, can serve as an ethical standard for judging the acceptability of a non-ideal health care system? To make a moral evaluation of public policy, some begin by determining if a consensus of public and expert opinion exists, either at or just below the surface; or, failing this, an historical trend of opinion that can set the boundaries for acceptable policy. At the present time, however, the values of the past are an inadequate guide. The huge inflation of health care costs, both in absolute terms and as a share of the Gross National Product (GNP), has occasioned a profound change in the nation's health policy agenda. Debate currently centers as much on finding ways to limit use of health services as it does on ways to extend access to health services. The introduction of the cost issue, together with reduced government resources for health care, has weakened the moral certainties that once seemed to underlie the nation's health policies.

Thus, the public needed more from the President's Commission than an incantation of familiar moral slogans and catch-phrases. The very simplicity of these slogans, which might have gone unchallenged in an earlier decade, makes them unsuitable as a guide to the subtle balancing and trading-off that a moral evaluation of health policy must now include as part of its task. And these simple sentiments are out of place in a debate in which the most basic assumptions of health care policy are being challenged.

The mandate given to the President's Commission has allowed a deeper reexamination of the moral foundation of the American system of health care delivery. Accordingly, the Commission set out to survey the moral issues involved in the access debate, to take notice of the moral principles relevant to these problems, and to provide its recommendations with a moral argument of a much more detailed and analytical kind than is ordinarily encountered in such documents. To this end, the Commission sponsored investigations into these moral perplexities by scholars from a number of disciplines. Prominent

among these are several works by philosophers, published in this Volume.

It is unusual for a public body to seek the counsel of philosophers in carrying out its work, but this was an appropriate time for such an invitation. In the last decade or so, moral philosophers in this country have undertaken to bring their methods and insights to bear on topics of public concern. This practical interest represented a sharp break with the academic orthodoxy of the time, which restricted the philosopher's domain to certain highly abstract issues with no direct bearing on determining what is right or wrong. About a decade ago, articles on current social issues, ranging from abortion to affirmative action, began to appear in professional journals, and monographs soon followed. Many of these philosophical contributions dealt with ethical issues in health care.

The philosophers who have addressed the moral implications of public policy issues have had several goals. At a minimum, they have sought to provide intellectual clarification—resolving ambiguities and exposing unnoticed premises and assumptions that occur in public debates over moral issues. A more ambitious goal has been to provide moral arguments for particular positions on these issues, arguments that meet certain standards of coherence, consistency, and logic. These arguments do not necessarily differ radically in nature from those that might be put forward by scholars in other disciplines or might be encountered in journals of opinion, but they have tended to have certain unusual strengths: a critical and questioning approach to received opinion on moral principles; an interest in ensuring that the moral premises used in a particular argument cohere with other basic beliefs and hence are part of a unified moral outlook; and a relative lack of partisanship and stridency. These qualities are nothing more than standard virtues of good scholarship; what is unusual is their presence in writing on ethics. The shift in philosophical practice had been premised on the thesis, now somewhat more widely accepted than it was a decade ago, that logic and reasoning are as important in moral debate as in science or other scholarship.

Moral philosophy, then, has endeavored to improve on intuition and sloganeering in an attempt to justify moral views on other than an *ad hoc* basis; when successful, it has provided rationales rather than rationalizations. These efforts have, however met with considerable skepticism, both from critics outside of philosophy and from philosophers who were never convinced that the turn to practical issues should have taken place. [Avorn, 1982; Beauchamp, 1982; Noble, 1982a,b; Singer, 1982; Wikler, 1982.] If the essays in this Volume are to be considered useful for informing public policy, some of these doubts should be aired and, however briefly, addressed.

The most basic doubt over the value of philosophical treatments of issues such as access to health care is over methodology. Philosophers do not conduct laboratory experiments or conduct surveys, and their results cannot be replicated. Further, the entire subject matter of ethics seems to many to be subjective, a matter of personal taste and attitude. The honorific title of “scholarship” and such notions as “proof” and “demonstration” do not seem appropriate, in the view of critics, to such a discipline; philosophers can offer merely well-articulated expressions of their personal beliefs—not objective support for policy decisions.

Philosophers cannot be fully reassuring in answering these charges; whether moral theory has any ultimate authority in matters of right or wrong is an open question in the field. It is certainly true that moral theorizing, like all human activity, occurs within a social context. Some axioms have to be accepted, without proof, as reasonable or self-evident, and these are probably subjective standards. Still, these facts do not sharply distinguish ethics from other disciplines, nor do they reduce the stature of moral theory to that of unreflective conventional morality. There is a point to getting one’s own values in coherent order, even if this does not establish them as objectively “true,” if only to lessen the chance of later remorse over having blundered into the wrong course of action. When what is put “in order” by a moral theory is the moral outlook of the entire society, we might yet achieve something like the set of “American values” that some seek as a foundation for ethical directives or health policy: a deeper consensus underlying the apparently inconsistent potpourri of current and past American policies. In any case, no secular alternative to what philosophers seek to provide has the desired objectivity, universality, timelessness, and classlessness. If moral philosophy is stuck in its social context, so is all moralizing; and if one rejects moral philosophy for want of objectivity, one must, to remain consistent, refuse to make moral judgments at all.

Doubts about objectivity and methodology are not the only ones that have been raised over philosophy’s role in public policy debates. Of equal seriousness is the feeling, sure to be experienced by some readers of these essays, that philosophical work on these issues is simply too far removed from mundane reality to have any practical import. Even when engaged in “applied” work on social questions, philosophers typically make numerous idealizing assumptions, speak at a high level of abstraction, and close up shop before spelling out many practical implications of their arguments. The policymaker or interested citizen may be left with the conviction that reading the philosophers’ essays cannot affect the decisions and judgments routinely encountered in professional or civic life.

Again, these doubts cannot be wholly laid to rest; it is true that many philosophical essays on topics of public interest

proceed on a level of abstraction quite unusual in most non-philosophical writing. But there are several excuses. The idealizing assumptions play the same role in philosophy as in other disciplines. Physicists, for example, are permitted to theorize on the assumption of such notions as frictionless systems because doing so permits the issues to be addressed a few at a time and hence to be developed in an orderly fashion. On the other hand, some of the otherworldly quality of philosophical writing comes from a willingness to take more into account than the reader may want. As Daniels notes in his essay, philosophers are not required to accept as much of existing policy as "givens" as are others, especially policymakers. This willingness to entertain the possibility of fundamental change—not just change within the realm of what is currently politically possible—may engender the belief that the philosopher is not speaking to the policymakers' concerns.

The very qualities of philosophical that prompt these doubts may also, however, be seen as strengths. Philosophical writing on moral issues aims to improve, in certain respects, on day-to-day ethical reasoning. The chief difference is that we ordinarily take no special pains to ensure that our moral judgments are systematic. On occasion we back up our moral views by reference to moral rules, such as the doctors' "First, do no harm." Rarely do we try to defend these rules, or to resolve a conflict among rules, by referring to higher-order principles. This is ordinarily just as well, for most of us would quickly find that our moral outlook is not organized according to any consistent principle or set of principles. The assumption underlying much philosophical work on current moral issues, however, is that a reasoned, comprehensive theory of social morality may be achievable; or, at least, that this ideal may be approached much more closely than is usually assumed. To the extent that this goal is pursued, the scope of intuition and ad hoc rationalization is reduced, and at the same time the debate is focused upon the most basic issues underlying the public debate.

If philosophical investigation were carried out at the level of individual judgment or moral rule, arguing only in concrete terms and never making reference to abstract or general principles, its bearing on policy choices would be much plainer. But it would lose some of its main virtues. On at least some occasions, we will want to question the validity of our specific judgments, intuitions and rules, and to ask about their standing vis-a-vis other plausible judgments and rules that seem to have opposite policy implications. Most of the philosophical essays published here take on this larger task.

A Budget of Problems

What are the problems of health policy over which philosophers have labored? Indirectly, most of moral philosophy's his-

torical topics concerns bear on health care. The chief issue particular to the health care area, however, is whether each person should be guaranteed access to some sizable set of health services. But this statement of the problem, while generally serviceable, greatly oversimplifies. In this section we examine some of the many ethical aspects of the access issue.

Equitable Access. Few commentators oppose the goal of equitable access to health services. The reason for this easily achieved consensus is, of course, that the term "equitable" is but a place-holder for a substantive moral standard for access. To libertarians, a market in which nearly no one could afford to see a doctor could, under certain conditions, be perfectly equitable. To some extent, the various moral theories and arguments concerning health care delivery have consisted of proposals assailing content to the notion of "equitable access."

Some have insisted that a satisfactory explication of equitable access is provided by the dictum, "Treat equally unless there are morally relevant differences," which is often proposed as the essence of justice.¹ Even if we accept this proposal, however, we could not give content to the concept of equitable access to health care without knowing what counts as a "morally relevant difference between various persons seeking access, and this is what most of the debate is about. True, some factors, such as race and religion, are obviously irrelevant from the moral point of view; and inequalities in access based on these criteria will rightly be judged inequitable by this standard. But the proposed standard does not help us to form judgments on inequalities in access associated with location (in rural and urban areas), age, ability to pay, prospect of rehabilitation, prognosis, or cost of treatment for type of illness. If there were consensus on whether these differences were morally relevant enough to justify inequalities of access, we would not need to proceed further with the philosophical inquiry.

A further difficulty in deciding which patterns of access are to be judged equitable lies in the explication of the notion of "access." Upon examination, the notion immediately bifurcates into what may seem to be quite distinct ideas. One is merely that doctors, hospitals, and medical services exist and may be used if one has the necessary means. The other includes, in addition, the stipulation that people possess the means necessary to acquire these services. Thus, access in the first sense would seem to be guaranteed if physicians are trained and hospitals and clinics are built; access in the second sense requires that prospective patients have the money, time, transportation, and liberty to secure the agreement of the providers to treat them.

¹ See below, subsection "Health Care and the Market"; Veatch, 1976; Outka, 1975.

Thus, many facets to the problem of access raise questions of equity. One might proceed in discussing justice in health care delivery by attempting a separate treatment for each: How much waiting time is equitable? How many physicians per thousand people ought there be? How many hospitals? In what follows, however, we will not pursue these questions independently; at a more fundamental level these questions of equity in access merge. A resident of a rural county in Wyoming or Mississippi might be able to use physicians and hospitals in Houston or New York for all but emergencies if he had the funds available to pay for travel and lodging; and if funds were unlimited, even emergencies could be handled by decently equipped (and terribly underused) emergency facilities in the rural resident's vicinity. Thus, financing could, in theory, assure availability and hence access. The existence of medical institutions in the total absence of the funds needed to use them, on the other hand—availability without financing—does not amount to access.

Thus the notion of access has at least two interdependent aspects: availability and means (including wealth, insurance, time, transportation, and other "enabling factors"). Without each of these, a sick person will not receive care. Yet even these do not make up the whole of "access." Attitude and motivation—"predisposing factors"—also matter: A person who doubts that medical care is of value will not seek it out. To an extent, this factor too is reducible to money. If cost were no problem at all, those who have some doubts about medicine's value might be willing to give it a try, whereas they would be reluctant to choose medical care over other needs if budgeting were required. And perhaps some of those who reject medical care would not do so if they were given the funds to restructure and reorient medical services and institutions to suit their tastes (though there will still be some for whom money is simply not the factor that stands in the way of utilizing medical services).

For these (admittedly not wholly conclusive) reasons, it is excusable to focus primarily on financing as the key to access. In any case, the philosophical literature makes hardly any mention of other barriers to care.

There is, however, a further, important justification for the present focus on the financing aspect of the access problem. Concern for justice in health care delivery must focus not only on the effect a family's finances have on use of health care services. Also important is the effect of the use of services on the family's budget. It is not clear in the writings of many of those who have championed universal health plans whether the evil addressed was lack of care (due to lack of money) or devastation of economic well-being (due to medical bills). The Committee on the Costs of Medical Care [1932], reporting in an

era in which inequalities (by income) in utilization of medical services were greater than at present, stated forthrightly that "equalizing financial impact of sickness is the heart of the problem."

In considering the impoverishing effect of realized access to medical care, we are considering more than the distribution of medical and other health services; we are widening our focus to include the distribution of wealth as a result of the services. This may seem to be needlessly and foolishly ambitious, for the rightness of given patterns of distribution of wealth is a subject that could never be adequately traversed en route to a theory of justice in health care delivery. Nevertheless, it must be addressed in certain of its respects. A "right to health care" in any context of scarcity implies a diversion of resources from other uses—and from other users. Public insurance programs, for example, may channel money from the well poor to the sick well-off. [Veatch, 1976; Coady, 1975, 1981.] Without insurance, a middle-income family with a chronically sick child may have less to spend on everything other than medical care than does a poor family in good health. Philosophical inquiry into health care delivery must consider whether programs ought to help the poor with their sickness, the sick with their poverty, all sick, or, as an alternative, all poor.

Distributive vs. Prudential Concerns. The interrelationship of wealth and use of health care forces us to work with a wider focus than we might wish when inquiring into the morality of existing patterns of access to health care. In particular, we cannot neatly segregate the *distributive* from the *prudential* aspects. An oversimplified illustration will convey the sense of this distinction. A given individual may choose to spend his money on radios and beer and have no way to pay for health care; in itself this behavior is, to most observers, foolish but not, on its face, immoral or unjust. Similarly a group of persons with about the same incomes who decide to pool resources for health insurance might unanimously choose low premiums and inadequate coverage, again to have more cash available for radios and beer. This again would, in itself, appear to be foolish rather than unjust or immoral. On the other hand, the failure of a community to provide to destitute members even that minimal health care needed for survival is quite obviously an action of questionable morality and justice. The same holds true for a society that refuses to allocate enough money for health insurance and to provide needed facilities.

Issues concerning the extent of insurance coverage, then, may or may not invite concern over distributive justice; the chief distinguishing feature in the examples just given is whether there needs to be a redistribution of money from the better-off to the poor so that the latter can obtain health care. To the extent that it is possible to distinguish the "prudential" from the "distributive" issues, these essays (and most of the

philosophical literature) emphasize the latter. Their subjects, in other words, are whether everyone must be provided with health care, and, if so, what kinds. Assuming that the requirements of justice are satisfied by some package of benefits that is less than the theoretical maximum, the relatively well-off individual will still have prudential choices about the purchase of additional services or insurance.

Nevertheless, much of the discussion in these papers concerns prudential issues. There are several justifications for this focus. One important reason derives from political realities. It is often stated that the manifest hesitancy of legislators to extend present health programs to those still in need is due to concern over costs. In particular, it is held that policymakers do not want to contemplate the costs that would be incurred if levels of coverage now provided in private health plans (largely a prudential matter) were extended to the poor who have no coverage. In a sentence: No equity without limits. If the universal coverage is to resemble that provided or chosen privately, the general question of limits must be broached. [Bayles, 1977.] Conversely, the acceptability of limits in as sensitive a matter as health care may require some guarantee that equity will not be threatened. [Fein, 1980.]

A second reason for considering the prudential and distributive concerns in tandem is that they are often intermingled in practice. Certain health insurance plans, such as Blue Cross, have by regulation featured "community rating," which precludes elaborate categorizing of insureds into risk categories with varying premiums to match. Without this feature, of course, families at high risk for expensive health care services would not be able to find health insurance at moderate cost. The regulation thus involves a redistribution of money from low-risk families, a distributive effect embedded in what might otherwise be an all-private insurance plan. Other insurance plans might omit coverage for such illnesses as tuberculosis and alcoholism (as have some hospitals required to treat indigents) in order to avoid redistribution of health benefits to the poor; patients with these (and certain other) illnesses tend to be low-income.

Finally, several of the philosophers represented here seek to investigate the question of access by reducing the problem (in a way to be discussed below) to a related problem of prudence. Some (though not all) of the questions concerning priorities among health care services to be offered to the needy recapitulate problems of prudence; i.e., of making expenditures for health care from one's own budget. [Bayles, 1977.]

Priority Problems. That a just health care system will provide some services and omit others is an inescapable, if unwelcome, fact. The requirement to make a choice presents a host of intellectual difficulties. Health care comprises a hetero-

geneous class of treatments and interventions, differing widely in effectiveness, cost, and purpose. Two kinds of priority problems arise: one between the many health services, and the second between health services and other individual and social wants and needs.

The first step toward establishing moral priorities is the setting of a boundary around the class of health services itself. This task is closely related to the task of defining health. Unfortunately, definitions of health have varied tremendously in scope and substance. The poles are the WHO definition, equating health with overall well-being, and a narrow conception of health that defines it as an absence of deviations from species-typical functioning in certain characteristic (but not solely) biological processes and activities. [Boorse, 1975; see also Kass, 1975.] The broadness of the WHO definition is pointed to by some authors as its *reductio ad absurdum* refutation [Daniels, 1981a], but it is seen by others as a basis for insisting on broad rights to well-being. [R. Green, 1976.]

The division of opinion on the definition of health is mirrored to some extent in a debate over the character of that definition. To some authors, health care can be defined only stipulatively as "those services provided by graduates of medical schools." To others, health, to the extent that it is freedom from disease, is a concept given objectivity and intelligibility by biomedical science. [Boorse, 1975.] Still others regard these categories as expressions of attitude toward the purported health state: Homosexuality is an illness if we wish to curb it, otherwise not. And to some authors an evaluation of a person as healthy or as ill (or diseased) is a statement about the person's functioning relative to a set of societal expectations and roles: Using this reasoning, pains in the joint could be considered an illness if it handicapped a young worker, but a natural discomfort if it struck an elderly nonworker.

Several theorists have taken seriously the link between the debates over access and over content and character of the notions of health and health care. Generally speaking, but with some exceptions, those skeptical of a right to health care have been most congenial to the view that definitions of health are prescriptive, or subjective. Those arguing for some sort of right to health care have endeavored to narrow the definition's scope and to supply it with an objective foundation. Both groups thus recognize that the notion of a right to health care is made less plausible if "health care" is made to include too wide a range of services.

Once the boundaries of health care have been determined, priority problems immediately arise. The philosophical task is to specify the principles on which the choice of health services is to be made. One step in this direction is to decide between subjective and objective criteria, between wants and needs. If a "right to health care" is a right to have desires for health serv-

ices satisfied, then perhaps the job of setting priorities should be left to the individual. If the entitlement is to having needs met, however, the priorities must be set according to a rational plan. The much-discussed "Consumer-Choice Health Plan" of Alain Enthoven [1980] prescribes a minimum set of health services by simply listing them. The list does not itself offer a principle of selection, however, and is therefore uncongenial to those who seek to specify priorities through moral argument. Determination of these principles is a chief concern of the philosophical essays in this Volume.

The balancing of health care needs against other worthy projects is an issue with a similar structure. Again, the primary question is whether this is to be left to the individual or must be settled by an objective criterion. In each case, the latitude for judgment is extremely wide. There certainly is no real limit to what could be spent on health; even if all beneficial services were provided, still more could be devoted to research. In any case, there may be a sizable reservoir of unmet needs of the ordinary kind. Overt demand by consumers is not a perfect measure of health needs. Many persons will change their life-style to accommodate illness or disability rather than attempt to correct these ailments. Forty-six percent were rejected from the draft in World War II for health reasons. Most diabetes and epilepsy remain undiagnosed, according to one estimate, along with 98% of cases of hypertension, glaucoma, and urinary infections. [Cooper, 1975, Chapter 2.] Yet the public debate over access to care is often conducted on the assumption that we know about how much we should be spending on health care, and, therefore, how much spending would be "too much." The amount spent on health care has risen sharply both in real dollar terms and as a share of the GNP; as the latter has approached 10% the alarm has sounded. No clear justification for this alarm has been provided, however (and alarms are heard also in the United Kingdom, which devotes closer to 5% of a much smaller—in size and per capita—GNP). We would do well to have a theory to tell us which new treatments and technologies would be worth extra dollars, even if the health budget is thereby increased. Similarly, we would welcome a way to determine when the rise in unit cost of a service makes it too expensive to be worthwhile.

Extreme Needs and "Bottomless Pits." Even when "health" is narrowly defined, its maintenance and restoration can become extremely expensive. New technology offers new ways to cure the sick and to assist the disabled. Some of these technologies, such as germ-free environments, can cost hundreds of thousands of dollars per patient.

Other patients can use up nearly as much money without needing anything exotic. It takes only a few years of repeat admissions to hospitals and multiple surgeries to run up a bill many times potential earnings. As more and more of the doc-

tor's caseload is composed of those with chronic disease, the share of medical resources concentrated on a small number of people will continue to grow. [Zook and Moore, 1980.] And costly benefits received may be only short-term; in 1975, 60% of hospital costs were incurred by patients who died within a year. [Menzel, 1982.] These figures might be much higher still if we provided the disabled and other medically needy persons with all the medical and rehabilitative care that would help them. One informal estimate predicted a 50% rise in medical expenditures, rising in share of GNP from 10% to 15%, if we did all we could.

The "bottomless pit" problem, then, has three aspects. First, some patients use (or could use with benefits) health care of practically unlimited cost. Even these expenditures would not, in some cases, be enough to restore such patients to the average health status of the rest of the community. Second, even if these needy individuals are left untreated (to some extent), medical resources likely will continue to be concentrated on a relatively small number of patients. Finally, the health benefits achieved by these expenditures are not always great. There is nothing in the nature of disease or medical care that guarantees a proportionality of expense and benefit. Chronic diseases are so called, after all, because they go on and on regardless of medical intervention.

Why are bottomless pits a *philosophical* problem? Because they seem to push certain theories of justice in access to medical care to extreme and, arguably, absurd conclusions. Any philosophical theory that identifies health care needs requiring amelioration by society must explain why *extreme* needs could justly be ignored. Care for the bottomless pits cannot simply be declared optional. Concentration of dollars on those with great need is precisely what is involved in a right to health care; why would any reasons against making the satisfaction of extreme needs a right not also suffice against requiring society to provide ordinary care? Why should needs generate rights, but only up to a point? If there is to be a threshold, it must be founded on some theoretical basis other than the need to avoid embarrassment to the theory.

The moral problem posed by extraordinary need is closely related to a further moral issue in health care, that of deciding what share of health resources should be devoted to the elderly. The elderly consume an enormously disproportionate share of health care resources at present, and this allocation may greatly increase as the population ages and as new technologies are developed for combating the infirmities associated with old age. The totally implantable artificial heart will literally be a lifesaver when it appears, but it will not be cheap. The access problem for the aged poses a special dilemma beyond that inherent in the problem of extraordinary need. The relative certainty of an upper limit to the life span ensures that re-

sources expended on the elderly will have a limited pay-off in terms of person-years saved. But age cutoffs and other devices for limiting care to the elderly seem intuitively to constitute the rankest sort of discrimination against a relatively vulnerable social group. Daniels's essay, Appendix K, considers the problem of justice for the elderly.

Freedom of Choice. Debate over health policy is often concerned with the freedom of various parties to make choices concerning health care, health financing, and health-related behavior. Physicians presently enjoy the freedom to choose many of the conditions of their practice, and moral arguments concerning access to care must seek to determine which of these freedoms are matters of entitlement or justice and must be preserved in any just health plan. Many consumers, too, have numerous liberties in choosing health care facilities and, in their role as taxpayers in a nation with no comprehensive health plan, they are to some extent free to spend their money on goods unrelated to health. Again, a comprehensive theory of justice in health care should determine which of these liberties must be preserved.

A further choice open to consumers is whether to engage in unhealthy habits, thereby creating health needs that would not otherwise have existed. A philosophical theory of just health care ought to determine whether these "artificial" health needs give rise to the same entitlements as other, "natural" needs for health care.

Freedom of choice and its bearing on the moral issues in access to health care are taken up by Brock and Sher in this Volume.

Health Care and the Market

Is Unequal Access Irrational? Most of the philosophers represented in these Appendices develop their views on access to health care in the context of moral theories. Earlier authors did not always approach the problem in this manner, offering instead less comprehensive principles from which they attempted to derive moral imperatives concerning access to health care. In this section we will survey some of these treatments of the access problem, turning thereafter to considerations of the more highly theoretical approaches.

In a much-quoted passage, the philosopher Bernard Williams [1962] argued that

Leaving aside preventive medicine, the proper ground of distribution is ill health: This is a necessary truth . . . the situation of those whose needs are the same not receiving the same treatment, though the needs are the ground of the treatment . . . is an irrational state of affairs.

Williams, in this early essay, branded as “irrational” any state of affairs in which people were treated differently for no relevant reason. This principle, he argued, is at least verbally accepted by nearly everyone, including those who act in the most unjust and discriminatory ways. Racists pay homage to this principle when they invent “evidence” that races differ in intelligence or moral character, for these qualities differ from race precisely in being relevant reasons for differential treatment of individuals.

Several writers on justice in health care delivery have closely followed Williams’s lead. Robert Veatch, in a well-known paper, endorses Williams’s reasoning, particularly the judgment that, despite the many existing differences and inequalities, “There is something essential about humans independent of their social, economic, and intellectual condition. This essential quality is sufficient to generate a claim of equality of treatment . . . (and) produces a strong egalitarian claim that cannot be refuted by empirical arguments pointing to the differences among humans in other less essential ways.” [Veatch, 1976; also see Outka, 1976.] From this premise, and from it alone, Veatch derives an imperative for a totally egalitarian health care system. In Veatch’s view, the claim that humans are essentially equal, whatever their differences, implies that health care systems should provide “the amount of health care needed to provide a level of health equal, insofar as possible, to other persons’ health.” The sickest would have first claim on available health resources, to the extent that these offer real benefits.

The argument from “essential equality” to total equality in access to health care has, however, failed to convince many philosophers writing on justice in health care delivery. Those who find fault with it include both critics and proponents of equal access. Peter Singer [1976], for example, complains that the logic of the argument applies equally well to the distribution of automobiles and practically any good or service:

Once we embark on this path of distributing goods and service on the basis of what is “obviously” fitting or relevant, there is no stopping place short of Marx’s vision of a society governed by the principle “From each according to his ability, to each according to his need.” . . . the fact that it is a quite general principle means that it cannot be invoked by those who claim that health care is *specially* unsuited to the market place. If ability to pay is sometimes relevant to how goods or services should be distributed, why is it irrelevant in this particular case?

Singer’s criticism shows that Williams’s premises, even if accepted, require some supplemental argument if they are to be counted on to support equal access to health care.

Williams’s argument is open to a second interpretation, that the basis for equal access lies not only in the “essential equality” of people but also, and perhaps primarily, in the nature of

doctoring, nursing, and other health services. Using this interpretation, morality requires equal access to health services because health is the "internal goal" of health care; and it therefore makes no sense to distribute health services on any other basis. This argument, however, is open to the same sort of objection as the first. Must a barber, asks Robert Nozick [1974], barber only the shaggiest? "Need a gardener allocate his services to those lawns which need him most?" And who is to decide what is a profession's "internal goal"? Nozick invites us to consider a new profession, "schmoctoring," whose "internal goal" is enriching the "schmoctor." That "schmoctoring" would provide health may be a welcome side effect, but, if Williams's reasoning were used, the first duty of the profession would be to make money.

How might a defender of the Williams-Veatch argument for equal access reply to these criticisms? It is possible, as Singer notes, to simply accept the fact that the argument applies equally well to all goods and services and so to endorse the principle "To each according to his need" (in fact, Singer [1976] is happy to do so). Few will accept the argument under those conditions, however, at least not under prevailing social conditions. Nozick might be answered by insisting that doctors by and large do cite healing as their primary goal rather than self-enrichment, and that if they did not, they would soon lose the confidence and support of the public. But this is to base the case for equal access solely on the avowed intentions of health professionals. This approach is problematic because doctors and nurses do have mixed agendas, and, more importantly, because provision of equal access to health care for all is a social project that transcends the subjective intentions of members of the health professions. Indeed, a requirement that health professionals allocate their services only according to need would be met in a society serviced by only a small number of physicians whose best efforts fell short of meeting acute needs. The resolve to provide equal access to all must be found in the society as a whole and not only in the will of health care providers. [Daniels, 1981b.]

If this simplest of arguments for equal access to health care is found wanting, then what is the reasonable alternative? The polar view is that health care is simply one more service, to be distributed by the market (assuming that we should have markets) like any other, whatever the resulting distribution. Indeed, in this view the only "irrational" principle of allocation would be distribution of health care according to need. An individual might prefer services or goods other than health services in order to meet other needs; how, then, can it be "rational" to institute a health care program that makes people less well-off than another, non-health effort might have done at the same cost?

This pro-market argument, however, is in itself no more successful in denying the morality of equal access to health care than the Williams's argument was (by itself) in supporting it. Few theorists favor distribution of *all* goods by the market. [Fried, 1975.] Individuals may wish to sell their votes, or to buy their way out of the military draft, but we persist in distributing these benefits and burdens either equally or according to criteria other than interest, desire, or ability to pay. Clearly, there is a deeper interest—perhaps social, perhaps even individual—in keeping votes out of the marketplace. We look to moral and political philosophy to clarify this interest. The “free-market” denial that justice requires any special pattern of access to medical care thus is significant less as an argument than as a challenge to determine whether health care has properties that set special moral requirements for its distribution.

Why Should Health Care be Distributed Differently? Many writers on equity in access to health care have contended that health services are not suited to the market, or, at least, that allocations of health care determined solely by the market are likely to be unjust. The grounds for these judgments have varied. Some have proposed theories of justice in health care, applying or developing general theories of distributive justice that do not give the market a role as the final arbiter. Some of these views will be discussed later in this introduction. Other arguments have been empirical, basing the critique of market distribution on estimates of the ways market choices of medical services are actually made. Finally, some have attempted to locate in health care a special, “moral” quality. These latter arguments are, perhaps, best seen as fragments of far more comprehensive theories of justice in health care delivery.

Hobbled markets. Perhaps the market, under ideal conditions, would permit each person to convert personal resources into personal welfare more efficiently than would any other system. It is now a commonplace of health policy research, however, that the market's functioning in the area of health services is hobbled by a number of problems, some specific to our own system and some that may be inherent in the nature of health care.

The principal defects in trade for health services, listed by Arrow [1963, 1965] and Titmuss [1968], center on the disadvantaged position of the patient as consumer. The average person cannot predict when medical needs will arise, nor how much they will cost. The consumer may not realize when he or she needs health care, and may, out of ignorance, reject the care when the need is felt. The consumer has no way to judge the quality of the service provided, or to choose between providers or even between health-related professions on the basis of quality, suitability, and price. Medical care cannot be “returned” if defective, and defects are in any case difficult to

detect and prove. The patient may be in great need at the time of the transaction, limiting his or her ability to shop around or dicker with providers for favorable terms. There may also be differences of social status and sophistication that put the patient in an unequal position in the transaction. Further, many prospective patients, such as those suffering acute psychotic episodes, may be mentally incompetent; many, including children, are also dependent upon others' financial support.

Further, providers limit consumer sovereignty in numerous ways, including withholding data on mortality rates and other indicators of quality, and even on prices; and these practices are enforced by provider associations. The market, for various reasons, often offers only a very limited choice among providers and health plans, and these may not differ in ways that would permit close tailoring of services to diverse consumer preferences. In many instances the market supplies one provider—or none.

Thus, the market for health care may involve a mentally incompetent consumer, or, if not, a consumer who cannot acquire enough information for a sound choice; the choices may be nonexistent, few or insufficiently diverse; the consumer may be the weaker party in transactions; and there may be no basis for feelings of satisfaction or dissatisfaction with the services and terms provided. Under these conditions, it is argued, the market cannot efficiently convert resources into utility. Some other mechanism for distributing health services, at least for those least well-served, must be sought.

This objection is, for many, stated to be the sole or chief reason for urging government action in assuring access to health care. It ought to be acknowledged, however, that it is not a complete argument. The market fails to provide us with any number of goods and services, and for some of the same reasons; Wagnerian opera is in a few respects analogous. Yet we do not insist on a "right" to these other goods simply because choices are few or prices high. We need a supplemental argument showing that if the market does not provide health services (at all, or efficiently, or without undue burden on consumers), the government or other powerful agency should. The criticisms of the health care market show, at most, that health care is "special" because it does not fit easily into the market; they do not show that it is "special" among the many non-marketable services because of a moral requirement to distribute it in some other way.

While the truth of at least a part of the critique of the pure market is generally recognized, it has not escaped debate. Many of the grounds do not apply, for example, to choice among health plans or insurance schemes. For example, the consumer need not be in urgent need at the time of purchase, and need for insurance is easier to predict and budget for than need for acute

care itself. Further, the “inefficiencies” in the market may actually be unavoidable, and appropriately assignable, costs. Transaction costs are ordinarily considered a normal part of the price of goods and services. [Lees, 1965.] And, as Gibbard claims in his essay in Appendix G of this Volume, a moral claim, not an economic one, is made when a market is deemed a “market failure” because of its inability to supply medical care to residents of sparsely populated rural areas except at very high cost. These arguments, if successful, would further suggest that the technical grounds for judging health care unsuited for the market must be supplemented by, or perhaps should be regarded as consisting of, a moral argument.

Background justice. Another general argument against reliance on markets for assuring justice in health care delivery points to the fact that markets, while they may preserve the justness of an initially just distribution, do not ordinarily make an unjust distribution more just. Almost every philosophical (or similar) argument favoring the pure market over assured access to health care begins with the crucial idealizing assumption that the general distribution of wealth be just. In the context of real-world, contemporary politics, these arguments must be counted as making only a small point. Passions do not run strong on the thesis that there would be a case against assurances of access to health care if wealth were distributed in a completely fair and just way. It has an academic cast. It does not constitute an argument for the pure market, and against a right to some package of health care services, in our present imperfect world.

The argument against the market, then, is that the existing distribution of wealth is unjust and that as a result a just distribution of health services would not be achieved even by a perfectly functioning market that proceeded from current allocations. That market may translate existing personal resources into personal welfare in the most efficient way possible, but the efficiency cannot in itself make up for the unfair starting positions.

Different authors have different reasons for holding our present distributions unjust. To some there is too little inequality; to others, too much; to many, the inequalities do not exist in the right places. Indeed, there is no general theory of distributive justice whose prescriptions match existing distributions. This fact should not be dismissed as the inevitable consequence of trying to project neatly formed theories onto a disorderly real world. According to a great many of the leading views, our society is gravely unjust. Robert Nozick’s *laissez-faire*, pro-capitalist theory, for example, condones the most extreme of inequalities and unmet needs; yet his theory seems to deny the legitimacy of the property held by most Americans since colonization and by those who have benefited from governmental redistributive efforts. [Nozick, 1974.]

It might be argued (see Gauthier's essay, Appendix H in this Volume) that the distribution of wealth, as opposed to that of health care, cannot be the subject matter of a theory of justice in health care; that it should be addressed instead by general theories of distributive justice. If this objection is accepted, then the caution over the justice of the society containing the health care system becomes relevant only when the insights of a theory of justice in health care are applied.

Not all writers, however, have assumed that the two subjects can be so clearly distinguished. One fundamental question posed to the pure-market view is whether the general distribution of wealth can be judged just or unjust without presupposing or using an independent theory of justice in health care needs. Daniels [1981a] argues that we might reject what seems, on every other ground, to be a just distribution of wealth, if the least well-off could not then afford what we believe to be a decent minimum of health care. Unless we determine that decent minimum of care, we cannot set the decent minimum of income or welfare envisaged by those who contemplate a pure-market approach. The idealizing assumption of the pure-market theorists thus turns out to beg the question for which the assumption was made.

Gauthier, however, in Appendix H, rejects this argument for the special case in which wealth is fairly distributed and health care needs are similar, but wealth is unequal. If under these conditions the poorest could not afford health care, he states, "it would show that society as a whole was unsufficiently affluent for adequate health care to be generally available." He adds, however, that the industrialized democracies are more affluent than this. Gibbard, in Appendix G, makes a related point in cautioning us that changes in the economic base and in the nature of health care costs may render inappropriate some moral judgments on access that would earlier have been uncontroversial.

The Ideology of the Market. Some pure-market theorists, as well as their opponents, are divided by differences in moral evaluations of certain key elements of markets. The most important of these is whether welfare should be identified with the satisfaction of preferences. Many theorists do not necessarily believe that even *informed* wants reflect needs or opportunities for well-being; as a result, the success of a well-functioning market in satisfying preferences may not count for much.²

Others find markets to involve too much luck, and to reward according to success in using trading opportunities rather than according to desert or another moral standard. (Telfer, 1976; Walzer, 1971.) The allocations made by any real market will reflect provider interests, payment mechanisms, and con-

² Dan W. Brock, *Distribution of Health Care and Individual Liberty*, Appendix J of this Volume.

ticiencies of supply that do not have any bearing on the rightness or wrongness of a society's allowing a person to remain ill when cures exist.

These anti-market views, of course, are in themselves insufficient to justify an entitlement to even a decent minimum of health care. A theory of health care needs, if distinct from a theory of health care wants, must determine what the needs are, how they may be determined, and why they should be met. Several such accounts are published in this Volume.

The Special Moral Character of Health Care. Singer [1976] considers the view "that it is somehow an intrinsic evil to make a commodity out of something essential for life." He rejects this claim, not because he accepts the pure-market view, but on the grounds that there is no way to show that making health care a commodity is *intrinsically* evil. (His own positive argument concerns the balance of good over bad consequences resulting from relying on the market for distributing health services.) Nevertheless, the feeling is widespread that health care resources needed for life itself should not be bought and sold.

The difficulty of making an argument out of these intuitions is in characterizing the "moral" quality of health care. One important quality of many health care needs is their "objective" character, objective in the sense that they are regarded as needs—and important ones, too—by nearly everyone, regardless of personality, values, or culture. Also important is that health states are in many cases prerequisites for the enjoyment of other goods. Loss of health could not be compensated for by provision of other goods any more than one could "substitute pieces of the walls for firewood in a fire used to keep one warm on a wintry evening." [M. Green & Waitzman, 1980.] Because health is a prerequisite of achievement, it is unfitting to use health care as a reward for achievement. [Donabedian, 1973.] Indeed, illness weakens the link between effort and success, and thus our ordinary reward system; and health care benefits could be provided without compromising the incentive system. [Stern, *et al.*, 1982.] Finally, the benefits of health care are also prerequisites for enjoying a normal range of opportunities for life's various pursuits, and providing this opportunity range may be especially important for social justice. [Daniels, 1981a.]

Further, relegating medical care to the market removes the assurance that our fellow citizens will come to our aid if medical calamity strikes, a comfort whose value must be very high, even if hard to quantify.³ Granting equality in access to health care may be an especially effective way to foster a sense of social solidarity and fellowship. [Crocker, 1977.] When a market exists for health services, such acts as saving a life and

³ Allan Gibbard, *The Prospective Pareto Principle and Equity of Access to Health Care*, Appendix G of this Volume.

restoring health are valued much less than they would be in a non-market system; such a cheapening of the gift of life is already noticeable (it is argued) in countries where a market in human blood exists alongside or has replaced a system of voluntary donations. [Singer, 1976.] A society that recognizes entitlements to health care defines its moral character in a way not possible in a pure market. [Taylor, 1981; Childress, 1979.]

These special facts (or alleged facts) about health care have been put forward by philosophers and others writing on equity in access to health care as possible grounds for providing greater assurance of access than the market is likely to provide. This introduction will not be the occasion to evaluate these arguments for the special moral status of health care, except to note that few have been developed in great detail (of course, they may be convincing nonetheless). However, this is largely true also of the opposing arguments. These suggestions thus differ in degree from much of the philosophical work commissioned by the President's Commission, which generally takes a more theoretical approach.

Theories of Justice in Health Care Delivery

Moral Philosophy. The articles on access to health services and on other social problems that have recently come forth from American academic philosophy are considered within philosophy to be "applied" work, however "theoretical" they may be or seem by comparison with other writing on the same subjects. Yet contemporary philosophy in this country has also experienced a resurgence of broad-scale social and moral philosophical theory. This phenomenon, usually dated back to the appearance in 1972 of John Rawls's *A THEORY OF JUSTICE*, actually anticipated the wave of "applied" philosophy. Professor Rawls's book, which was immediately accorded the status of a classic, provides a set of richly detailed and novel arguments that aim to establish a standard for the design of the basic institutions of society, a standard that must be met if the society is to be considered just. The intellectual depth and rigor of this work seemed to many to prove, by example, that philosophy as a discipline can make an important contribution to public affairs. Since 1972, several works of similar scope and ambition, though with markedly different outlook, have appeared, and these works have spawned a sizable secondary literature.

The interest of philosophers in comprehensive social and moral theory was more a rededication to these tasks than anything new; some of the great philosophers of the past are revered precisely for their contributions in this field. Indeed, each of the major new theories is plainly a development of much older ideas. Rawls is insistent on tracing some of his key moves to Kant; Gauthier's contractarianism recalls Hobbes; and the

libertarianism of Robert Nozick incorporates much of Locke's political philosophy. The utilitarianism of Bentham and Mill has been with us all the while, and in its several contemporary versions it retains a stature comparable to the others.

Much of the best applied moral philosophy has been informed by these theoretical developments. In some cases, the "applications" are simply that: attempts to deduce some directions for policy on a specific problem from the general principles supported by one particular theory. Other efforts are less tied to any one theory, but they use theoretical devices and concepts put in currency by these theories. Both of these relations to general moral and social philosophy are evidenced by the philosophical essays on access to health care that appear in this Volume. We will introduce them in the context of the comprehensive social and moral theories or theoretical traditions that they develop.

Rawlsian Theories. Rawls's influence on contemporary social and moral philosophy has been great, and his book has been widely read by social scientists, lawyers, and others concerned with the achievement of a just society. It is thus natural that philosophers and other writers concerned with justice in health care delivery have looked to *A THEORY OF JUSTICE* for cues on framing standards of equity. We will provide the briefest of sketches of Rawls's theory, will consider its suitability as a background theory for a theory of justice in health care, and will describe one sustained effort to fashion a Rawlsian approach to access to health care.⁴

Rawls uses the notion of a social contract as a guiding metaphor for fashioning his theory of justice. His theory proposes a conception of justice as fairness, a quality that may be built into society's basic institutions by regulating them according to standards to which society's members would agree prior to learning of their individual needs and advantages. Thus the game is fair, whoever wins, as long as it is played according to rules agreed to in advance.

We are to imagine, then, that individuals representative of those who will live in a society meet to decide on society's ground rules under a "veil of ignorance" about many of their individual qualities and assets. They are then to opt for policies most likely to further their most basic interests, to the extent that these can be estimated while under the veil of ignorance. Rawls argues that the "votes" on key provisions would be unanimous, since reason dictates but one set of rules when operating under these constraints on knowledge. As Gauthier notes in his essay below, the notion of a "contract" serves mostly as imagery

⁴ For a critical survey of the main theories of distributive justice, including Rawls's theory, and their application to the issue of health care, see Buchanan, 1979.

in Rawls's theory. Social contracts are always hypothetical in contractarian theories, but in Rawls's case the unreality of the contract is even greater. What Rawls has in fact done is to reduce the social problem of justice—which concerns the distribution of benefits and burdens between individuals (and classes and generations)—to questions of individual rational choice under conditions that reflect both the problems principles of justice are supposed to solve and a certain conception of the person as an autonomous agent. Since reason under the veil of ignorance has but one path to follow, according to Rawls, the suggestion is gratuitous that the ground rules are derived from agreement among many rather than by a decision of one. That the rules for a just society are derived, in effect, from one person's rational deliberations is a favorable development in theorizing about justice. If the interpersonal issue can be resolved by determining what a single individual would choose, even if this must be considered in highly artificial circumstances, then the task is greatly simplified.

Rawls's theory not only presents the contract-under-ignorance device, but also attempts to determine what the contractors' reasoning would have to be. Rawls arrives, through intricate argument, at a small number of general principles of distributive justice. The first provides for an equal and extensive system of basic civil and political liberties for all. The second permits social and economic inequalities, as long as two conditions are met: The inequalities must be necessary for maximally benefiting the least advantaged (the "difference principle"); and "fair equality of opportunity" must govern the pursuit of all positions and offices. These principles govern distributions of what Rawls calls the "primary goods"—those goods important to all people, regardless of individual plans and goals, because they facilitate the critical formulation, revision, and effective pursuit of "plans of life." These goods include such "social" goods as liberty, wealth, and natural endowments. Rawls classifies health as a "natural" primary good because its distribution is, in his view, largely beyond society's control.

One of the striking features of Rawls's theory is its relative freedom from reliance on intuition. Rawls sought to improve upon those discussions of distributive justice that were carried out in terms of several "canons of justice," standards each of which seemed to capture part of our sense of what justice is. Thus, one traditional standard called for distribution according to merit; another for distribution according to past contribution; and so on. Intuition was called upon not only to serve as the basis for advancing each of the canons, but also for deciding on their relative importance. Nothing but intuition could determine, for example, whether to transplant the one available kidney into an old soldier (past contribution) or a budding scientist (future contribution); such a distributational scheme

hardly constitutes a theory. By contrast, Rawls provided a criterion for acceptance of any principle of justice; i.e., whether it would in fact be accepted by all reasonable persons under the veil of ignorance; and he provided detailed arguments in an attempt to demonstrate that the principle he endorses would be chosen.⁵ Further, indeterminacy in choosing between conflicting principles, a major problem of the intuitive approach, was avoided. Rawls argued that the “contractors” would insist on a strict hierarchy among the principles. First, the equal liberty condition must be met; then, the principle of fair equality of opportunity; finally, and only if the other two conditions are satisfied, the difference principle is to be invoked.

How might Rawls’s theory be applied to the problem of access to health care? We must first ask whether the theory is capable of this sort of application at all. Several commentators have expressed skepticism on this point. [Beauchamp, 1980; Daniels, 1979.] Rawls, as we have seen, simply did not regard health as a good that can be “distributed” in any important sense. More importantly, Rawls addressed himself to the design of the basic structure of society; beyond this, any number of social arrangements that might be arrived at within this structure would satisfy the requirements of justice. (It is unclear whether the health system could be counted among the societal institutions making up this basic structure.) Equally important is one of the idealizations used by Rawls [1982, p. 168.] in framing the argument:

I . . . assume that all citizens have physical and psychological capacities within a certain normal range. I do this because the first problem of justice concerns the relations between citizens who are normally active and fully cooperating members of society over a complete life.

Nor is it clear that Rawls’s theory would remain much the same if it took into account the wide variations in individuals’ need for health services. Rawls [1982, p. 168] admits the possibility that “the idea of primary goods may have to be abandoned . . . a different or more comprehensive notion than that of primary goods . . . will, I believe, be necessary . . .” Those (other than Rawls) who have expressed these cautions have not meant that Rawls’s theory founders in confronting the access problem, but rather that it may simply have no important implications concerning access.

The most natural way to try to extend Rawls’s theory to cover health needs is by proposing to classify health care as a primary good, the distribution of which would be governed by the difference principle. Veatch [1976] thus construes the im-

⁵ It must be noted, however, that since Rawls’s principles apply only to the basic structure of society, they do not help us to decide who gets that kidney.

port of Rawls's theory, and his rejection of a Rawlsian theory of justice in health care delivery is largely based on his unwillingness to countenance the inequalities sanctioned by the difference principle. Gauthier's discussion of Rawls, briefly stated in his essay (Appendix H), entertains a similar development.

However, this approach faces certain problems that cast doubt on its adequacy as a theory of justice in health care delivery (and as an application of Rawls's general theory). First, as Arrow [1973] has noted, under this scheme of distribution extreme health needs would threaten to hijack the entire economy. The gravely ill are, regardless of other assets, among the worst-off in any society. The expense of making these people as well-off as possible might be enormous and yet might still fail to bring them up to the level of welfare enjoyed by most others. If, on the other hand, we attempt to balance needs for health care against other basic needs in some sort of index of primary goods to which the difference principle would apply, we require a principle to govern the weight that is assigned to the health care need. Reliance on intuition to decide this trade-off of health care against other needs negates the rationale for developing a theory, which was to improve on intuition as a guide to policy.

Ronald Green has argued that health care would be singled out among the primary goods for special consideration by the contractors, who would not want to permit trade-offs against other primary goods in an index. Green thus argues that health care should be given the same kind of priority in distribution as Rawls thought liberty would have. As Daniels has noted, however, the arguments Rawls marshalls in support of equal rights of liberty do not carry over naturally to health care; the contractors, under the veil of ignorance, do not know enough about their future needs and assets in areas other than health to be able to assign the relative priority of health care. Health care thus looks more like food, shelter, and other primary goods that admit of trade-offs. [Daniels, 1979.]

Daniels [1981a] has produced an alternative Rawlsian theory of justice in health care delivery, one that focuses on the function of health care in fostering certain opportunities. Following Boorse [1975], Daniels defines health narrowly as negative deviation from species-typical functioning, Daniels argues that the moral significance of poor health goes beyond the unpleasantness of pain and disability. What makes prevention and cure of illness a matter of justice is the vital link between health and the opportunity to choose among a normal range of life plans. People with severe illnesses do not have the same opportunities as others; even if illness strikes later in life, after most of one's life plans have been made, the ill person loses the chance to revise the plan and to pursue new goals.

Rawls had noted the crucial importance of education in facilitating fair equality of opportunity; Daniels is thus propos-

ing that health care be treated in the same way. To do so is to accord to health care a status higher than any of the social primary goods that comprise the index and are allocated according to the difference principle. In Rawls's strict ordering of principles of distribution, the principle of fair equality of opportunity is to be satisfied before the difference principle is invoked; there can be no trade-offs between the two. By grounding the importance of access to health care in the opportunity principle, Daniels leapfrogs the index and assures that health care will be given high priority.

Thus, Daniels derives a theoretical rationale for the claim that justice requires access to medical care. Furthermore, Daniels's theory is capable of assigning priorities among health services: Justice will be concerned with those forms of care with important effects on opportunity. Other kinds of care, while they may be desired more intensely, will be matters of prudent expenditure or charity. Thus, in Daniels's view, justice requires access to some, but by no means all, health services, and those are specified by their actual relation to opportunity rather than by the subjective appeal they may have to a given consumer.

Daniels's theory is notable both for the degree to which it attempts to provide developed and consistent answers to the basic questions of equity in access, and for its effort to locate a foundation in a careful interpretation of what many regard as the leading moral theory of the day. Nonetheless, it has been criticized on both these points. Buchanan, in Appendix I, questions the notion, crucial for Daniels's theory, of a "normal" range of opportunities. It is apparent that a principle of fair equality of opportunity which concerned itself with the opportunities Daniels means to include in this range—namely, those life plans possible if individuals are assured of average health—differs considerably from Rawls's principle. It is not clear if the arguments that Rawls marshalls for his principle also support the principle of Daniel's theory with the same name. This difference raises the question whether the Daniels approach is truly Rawlsian, and hence whether it gains plausibility from the association with Rawls' work. Daniels actually is not especially concerned to wrap his theory in Rawls's mantle. His claim is, rather, that his argument establishes a basis for equity in access to health care that will follow from any theory of justice that includes a principle of fair equality of opportunity like the one he proposes. Daniels suggests that Rawls's theory is one of these, but this is not a central claim.

Buchanan, in a further criticism, holds that Daniels's principle is not as determinate as claimed. Other principles, or intuition, or both, are needed to fix the relative priority of health care under conditions of scarcity, for without these factors we cannot determine the scope of the normal range of opportunity. Some limits must be set, for a society that tried to

guarantee all opportunities to all persons would soon face bankruptcy.

Daniels responds to some of these criticisms in Appendix K. He makes clear that normal opportunity ranges are defined relative to an individual's skills and talents. Thus, justice does not require that every short man have the opportunity to play professional basketball, or that the tone-deaf have access to the conductor's baton. This proviso removes at least part of the indeterminacy that Buchanan detected in Daniels's theory of justice in health care delivery.

Bargaining for Justice: Gauthier. David Gauthier's views on distributive justice, as put forth in a series of papers [1974 a, b; 1978] including that published here, bear a superficial resemblance to those of Rawls. Both Rawls and Gauthier contend that the principles of distributive justice are those that would be endorsed by representative individuals engaged in bargaining under certain defined conditions in order to maximize their own individual welfare. And they share a vision of what sort of enterprise a society should be: in Rawls's words, a "cooperative venture for mutual advantage." However, the theoretical device of the contract used by Gauthier to generate the principles of justice differs in important ways from that used by Rawls, and as a result the principles of justice endorsed by his theory present a quite different picture of the just society. The sources of the differences between Gauthier and Rawls are philosophically deep, involving different conceptions of the nature of morality, of the subject matter of justice, and of persons. These cannot be explored adequately here, but it may be useful to highlight some of the differences in theory that are most relevant to the implications of Gauthier's views for the problem of access to health care.

Gauthier views the principles of justice as the outcome of deliberations between individuals representative of a society, undertaken so as to structure interaction and cooperation for the greatest benefit of each. The resulting principles will, of necessity, be a compromise: The bargainers may not get all that they want, but the society governed by the principles will deliver more to the individuals than they would have realized without the regulated cooperation. For Gauthier, then, as with Rawls, a theory of justice consists of a general statement of the terms and conditions of the bargaining process, together with an attempt to spell out the provisions that would be accepted (so far as these are determined by the terms and conditions of the process). A crucial difference is that for Gauthier the bargainers would not be placed under Rawls's veil of ignorance. They would be kept in the dark about certain matters, such as their actual social status within the society they will actually live in, for the social structure is to be determined by the bargaining and ought not play a role in deriving the prescriptive principles. But the contractors will be fully aware of their own

talents, capacities, and tastes, as well as those of their fellow bargainers. Only then could they judge whether the bargain they strike represents an improvement over what they might have been able to obtain without cooperation; this is the standard for judging whether social cooperation truly does yield mutual advantage. In Gauthier's view, the individuals under Rawls's veil are abstracted too far from their actual selves, which in reality are largely constituted by the very talents, capacities, and preferences made invisible by the veil. This abstraction makes it reasonable for Rawls's contractors to consider individual talents and capacities as common assets of the community, whereas for Gauthier they are reserved first of all for the direct benefit of the individual who has them. Rawls's theory is thus (and for other reasons as well) far more egalitarian than Gauthier's, though both permit significant social inequalities. Rawls's principles require considerable redistribution of wealth, while Gauthier's principles have more to do with justifying expenditures on such public goods as roads and harbors, from which all benefit, than with redistribution to ensure greater equality of welfare.

It is thus noteworthy that Gauthier insists that access to health care should not be based simply on ability to pay. He does not reason that differences in wealth and income should not be reflected in differences in health or in use of health care services. Indeed, he holds that wealth and health care utilization ought to be correlated, other things being equal. Purchases of health services beyond the minimum will be a good buy from the perspective of the rich, but not from that of the less well-off. To equalize access to health care for those whose different levels are due to economic inequality would actually be unjust, if this "would give rise to a claim on the resources legitimately acquired by other persons." (Though we must note that Gauthier holds that, in a society conforming to the principles of justice given in his theory, each individual will be sufficiently well-off to satisfy average needs, if the society has become "moderately affluent" and if his or her position has not been unjustly worsened by others.)

Gauthier's opposition to a purely free-market approach to access to health care is based instead on the significance he attaches to two features of health care. The first is that the need for health care, unlike that for most primary goods society could distribute, varies enormously from person to person; the other characteristic is that health is "accidental" (in a sense to be explained below) to the person. The conjunction of these two facts with the premises of Gauthier's theory of justice yields the conclusion that health care deserves a special method of distribution.

Gauthier holds, as we have noted, that a person's talents and capacities are part of his or her identity; the individual cannot be imagined in abstraction from these traits. It is "only

partially metaphorical” when we say of a person who has undergone a marked and unexpected change in character that he or she is no longer the same person. These personal qualities set constraints on the kinds of goals and enjoyments to which a person can aspire: The especially imaginative, according to Gauthier, have lives of “a finer texture.” People deserve what they obtain by exercising these talents, even though they cannot be said to deserve the talents themselves. Nor can these capacities be much enhanced by social intervention.

Health, according to Gauthier, is an entirely different sort of personal trait. A person’s health is not a part of his or her identity; it is, to use the philosophical term, an “accidental” rather than an “essential” quality. The consequences of one’s bad health are not to be charged to the individual in the same way that we credit (or debit) a person with the consequences of his or her talents or character. The principles governing the allocation of resources should, then, be drawn up through bargaining by individuals who are considered in abstraction from their own health needs. A set of principles derived from a bargain among persons who take into account their own *health states* would be unjust, in Gauthier’s theory, just as in Rawls’s theory *talents* and *capacities* must not be taken into account.

Gauthier does not, however, imagine that his contractors will endorse, for the special case of health care, the principles that Rawls’s contractors adopt for primary goods in general. In particular, according to Gauthier, they will reject the difference principle, according to which the only permitted inequalities are those that most improve the lot of the worst-off. Least of all, Gauthier argues, would they agree on full equality of access. The equalizing effect of the abstraction from health care needs in Gauthier’s bargaining situation is (he notes in Appendix H) instead, that inequalities in access will reflect mainly differences in personal resources, “insofar as these are determined by principles of fair distribution related to the differing characteristics and deserts of individuals” (excepting health care needs). Thus, people may differ in income and status in the just society, and their health care expenditures will reflect these differing levels; but the differences will reflect only variation in essential qualities and not in such accidental qualities as health state. As Gauthier develops the implications of his foundational concepts, the criterion for distribution of health would be cost-effectiveness, the maximum health per dollar. Those who have no special knowledge of their individual health needs will choose to insure themselves for cheap, effective health services rather than expensive services of doubtful effectiveness, if scarce resources force a choice (as, according to Gauthier, they must do).

Gauthier’s prescription for just access to health care, then, is neither egalitarian nor purely market-oriented. Though the identification of unequal need as the chief issue of ethical

concern is due to Gauthier's own theory of morality and justice, the rules governing the specification of the "decent minimum" of care to which all are entitled has a utilitarian character. We turn, then, to utilitarianism and its implications for access to care.

Utility and Justice: Gibbard. Utilitarian theories of morality are those that judge the morality of actions and policies by their potential for bringing about the greatest balance of well-being (happiness, satisfaction of wants and needs) over pain, suffering, and deprivation. On other points these theories differ widely, which is why reference to "utilitarian morality," in the singular, is misleading. According to one utilitarian theory, the test of utility (productive of good over bad) is to be applied to individual actions; according to another, only to rules or policies. Some utilitarian theories urge maximization of aggregate utility; others of average utility.

Each of these utilitarianisms is a comprehensive theory of morality, and presumably of justice, and each might be assessed for its implications for justice in access to medical care. This would require a large effort, one chiefly of academic interest in the absence of persuasive claims on behalf of any one. Buchanan and Gauthier provide careful and lucid general expositions of utilitarian approaches in their essays herein; we will merely recall a few of the main points here. Then we will address the theory put forward by Allan Gibbard in his essay, Appendix G in this Volume, which proposes, if not a full-blown utilitarian theory of justice in access to health care, then a perspective from which the utilitarian approach is made to seem especially appealing.

Utilitarian moral philosophy will endorse equal access to medical care, or universal access to a decent minimum, or a free-market approach, depending on which of these is most likely to produce the greatest sum of happiness or other mode of well-being. Quite obviously, it is not possible to deduce from utilitarian principles alone which of these policies is the correct one according to this standard. Much depends on the particular social context of the health policy. Still, a few generalizations may be stated.

As Buchanan notes, health care may produce utility indirectly as well through the direct relief of suffering. Healthy people can do more good for themselves and others. This fact marks health care as a relatively good use of funds from a utilitarian point of view. Moreover, the utilitarian standard tends to endorse equality in distribution of most goods, since those with much derive less satisfaction from an extra measure than would those with little. Equal access to health care would be an instance of this effect in most cases; and it would also help to redistribute wealth generally, which would increase aggregate utility still further. [Singer, 1976.] Gibbard notes that

there may also be certain benefits of feeling, such as fellowship, from a policy of equal access to health care; Peter Singer [1976] argues that such altruism tends to encourage more of the same, adding still more utility. Brian Barry [1965, Chapter 7] and Robert Veatch [1976] have argued independently that a policy of strict equality of access, in which the rich and powerful get no more and no better than the least advantaged, would motivate the former to press for a high standard of service for all. This is another way in which a policy of extensive and equal access to health care could be expected to result in a favorable balance of utility.

Nevertheless, there are general reasons to doubt that utilitarianism supports extensive and equal access. Other needs may be more pressing, and the poor might wish to forego the health benefits in favor of other goods, as Gauthier and Gibbard note. Furthermore, those who are very sick may realize little benefit even from much expenditure. Unless they are capable of rehabilitation with a limited course of health care, they would not be beneficiaries of a health system run on utilitarian principles. The "decent minimum" would thus be not a minimum level of health, nor even a minimum amount of health care or health care dollars, but rather a minimum of cost-effectiveness that any treatment to be offered would have to have.

To some observers, exclusions of the worst-off seem intuitively unfair. Veatch, for example, rejects utilitarian approaches to equity in access for this reason. This complaint is, indeed, consonant with the most commonly encountered objection to utilitarianism, that its exclusive focus on the aggregate causes it to ignore that some distributions of utility within a population are far less just than others equal in aggregate size.

It is in the context of this charge, that utilitarianism endorses terribly unjust distributions, that we may turn to Gibbard's paper; for one of its achievements is demonstrating that endorsement of some of these same distributions will follow from acceptance of a principle that seems initially to be quite innocuous.

Gibbard begins by consideration of a simple moral rule: If a policy would make no one worse off, and some better off than under any alternative, then it is a better policy. This "Pareto principle," while not quite self-evident, is relatively uncontroversial. It is also quite limited in its applications, however, for most policy choices involve deciding among policies that do make some people worse off.

But Gibbard gains most of what he is after by proposing what may seem to be but a minor change in the Pareto principle. The revised principle reads almost the same, but it applies to prospects: a person's chances of doing well in a process that, at the time of distribution, has not yet begun. We buy prospects when we buy insurance policies, and we compare prospects

when we shop around for these policies. The revised principle essentially calls for that distribution of insurance policies and premiums which could not be bettered in the sense of Pareto; i.e., the policy that distributes prospects in such a way as to improve the prospects of some, and worsen the prospects of none, relative to the results of other distributions. This “prospective” (or *ex ante*) Pareto principle has much wider scope than its predecessor; for, as Gibbard states, interests are much less likely to be opposed in prospect than in retrospect.

Unless we peek ahead and see the logical implications of the prospective Pareto principle, we may be inclined to pronounce it, like the simple Pareto principle, uncontroversially true. What is surprising, then, is the degree to which the principle approximates utilitarianism, at least if the prospects are “distributed” from, say, the moment of conception. Gibbard supports a universal decent minimum (though here he supplements the prospective Pareto principle), but he entertains the possibility that morality need not require very expensive treatments or strictly equal access to health care. The reasoning that takes us from the prospective Pareto principle to these tentative judgments⁶ recalls that provided by Gauthier in drawing up his theory’s principles of justice. In both cases, what may to seem some readers an unpalatable rejection of some of the neediest is neutralized by the observation that, even if an individual is unlucky enough to end up with unmet need, the policies of distribution were drawn up in such a way to offer (prospective) maximum benefit to that very individual. Of course, it is worthwhile to spend some amount of money to resolve the bad feelings that would result, even if these feelings are unreasonable. But as the cost of saving lives through medical care rises, Gibbard suggests, it may be better to adjust our thinking (“about risk, and about what we owe each other in the way of extraordinarily expensive treatments”) rather than to insist on paying the price of a misguided morality.

Legal Rights Without Moral Rights: Buchanan. Libertarianism assumes that people have a full set of “negative” rights (principally, rights of non-interference), but no rights to well-being at others’ expense. It is morally irrelevant that an illness may be due to no fault of a patient, according to standard libertarian texts [Nozick, 1974]; needs do not give rise to rights. The only “rights” in access to health care, according to this strict libertarian view, are the rights of property owners to their property, which must not be taxed or otherwise appropriated in order to pay another’s medical bills.

Libertarians who have addressed the problem have stated bluntly that access to health care in a society conforming to libertarian precepts should depend entirely on ability to pay.

⁶ These judgments are tentative because they require empirical validation.

However, we cannot conclude from this that the market must distribute health care in our present society. Contemporary America is not a libertarian land, and nowhere is this more evident than in the health care system. Libertarians argue forcefully, for example, against licensing laws for physicians and other health care professionals. Non-libertarians may believe these restrictions on trade are justified, but there can be no denying their effect on access to care. Further, many libertarians oppose the social investments in health care, such as aid to medical education and sponsorship of research, that have been financed through taxes. These, too, have had a major role in shaping our health care system.

The most significant difference between our society and the libertarian utopia, however, is on the issue of private property. Libertarian theorists take great care in specifying how property might be legitimately acquired. The conditions they cite, which permit the creation of wealth, voluntary transfer, and little else, are stringent. The key libertarian premise is that property justly acquired may justly be kept or voluntarily transferred to others, but may not be seized or appropriated. This principle is silent, however, on whether property unjustly acquired can be seized or appropriated. The question of whether equal access to health care might be assured by redistributing income through taxes, then, depends on the actual history of acquisition of private property in America. That history has no artificial starting point; generations of proper transfer of wealth unjustly appropriated does not "purify" the holdings. If a significant portion of the property that would be appropriated in a governmental effort to assure access to health care were originally acquired by means that did not meet the libertarian's stringent standards, libertarian theory would not brand that effort unjust (at least not for the same reasons that would be given for such a verdict on appropriation of property legitimately acquired). It is quite uncertain, therefore, whether there is a libertarian position on access to care in real society (though there are, of course, accounts of the access problem that reflect a generally libertarian point of view).

Allen Buchanan, in his essay *The Right to a Decent Minimum of Health Care* (Appendix I), offers a suggestion for reconciling libertarian moral theory with governmental efforts to assure access to medical care. Buchanan recognizes that libertarian principles deny the propriety of using the government's power to enforce a moral right to health care, where this right is thought to derive from need, concern for equality of opportunity, or interest in maximizing utility. Libertarianism is unequivocal in its lack of regard for these aims. These libertarian strictures do not, however, deny the possibility that other considerations might legitimize governmental programs. Buchanan develops a rationale for state action that may be more congenial to the libertarian outlook.

There is nothing in libertarianism, according to Buchanan, that denies the existence of a strong *personal* obligation of charity or benevolence. Individuals, if they are moral, will want to discharge these duties. Providing health care for those who cannot afford it will, for obvious reasons, appear to many to be an ideal way of meeting this requirement. Those who wish to do so, however, will face certain difficulties. Many health care services cannot be made available except by a large-scale, coordinated effort. Enough individuals may be interested in providing these services to provide the necessary funds, but each may be unwilling to contribute without assurances that enough others will do the same to ensure the project's success. Rational givers will endorse a plan requiring participation, for this is the only way prospective participants can know that those conditions will be met.

Nor is the need for coordination the only possible justification for action by the state. Libertarians recognize the right of the authorities to force transfers needed to compensate those whose rights have been violated in the past. If many of the presently disadvantaged owe their difficulties in achieving access to health care to past unjust deprivations, as is arguably true for blacks, Native Americans, and certain other minority groups, then state assurances of access to care may be in order.

When health programs undertaken on these grounds are considered in tandem with the programs that might be enacted to coordinate charitable efforts, we have, in Buchanan's view, something close to a governmental assurance of access. Granted, there is no reason to suppose that such a program will offer more than a decent minimum, and it certainly would not attempt full equality. It would, however, be a broad-scale social assurance of access to health care that would, Buchanan argues, be compatible with fundamental libertarian precepts. There may be no *moral* right to access to health care that would convince a libertarian that government intervention is justified; yet libertarians might accede, according to Buchanan, to the need for a *legal* right. Thus, Buchanan's approach challenges the widespread assumption that an enforced policy guaranteeing a decent minimum of health care must be grounded either in a moral right to a decent minimum or in utilitarian reasoning.

Special Problems

The remaining essays deal with issues of great importance for understanding the ethical dimensions of the problem of access to health care. These issues are, however, "downstream" from the fundamental concerns of the essays just discussed. These papers do not attempt to derive a general justification for, or prohibition of, efforts to assure access to health care, but address problems within the theories that do. Since, as a group,

the essays in this section are less suffused with philosophical jargon and theory, little introduction is required for the general reader.

The Elderly. Aging presents a problem of equity in access to health care because the aged require a highly disproportionate share of health care resources. Norman Daniels's essay, *Am I My Parents' Keeper?* (Appendix K) is an examination of the kinds of reasoning that determine whether that share ought to be regarded as morally appropriate, or as too much or too little.

The problems of the aged attract attention for several reasons. It is an especially important instance of the general question of the relation of equity to equality in access. The problem of the "bottomless pit" also arises, since huge expenditures may produce some small benefit and yet fail to restore the aged patient to the level of health enjoyed by most others. Finally, aging presents a challenge to Daniels's own theory of distributive justice in health care delivery. Daniels saw health care as required by justice because of its effects on opportunity. This would seem to suggest that justice does not require health care for the aged, since most of their opportunities are past. This verdict seems harshly discriminatory and raises intuitive doubts concerning the adequacy of Daniels's account as a theory of justice.

Daniels's own interest in the problems of access faced by the aged may have been sparked by the theoretical challenge to his own general treatment, but his essay addresses issues of general concern. Daniels's strategy is to develop an account of justice for the aged as a response to the question, "What is age bias?" Would a health system that refused dialysis to those over 65, for example, be biased toward the elderly? Conventional thinking might regard this as a paradigm case: The exclusion treats the aged as a group, regardless of individual characteristics or differences, singling them out for inadequate care. Refusal to extend dialysis to members of a particular ethnic group would clearly be an instance of bias: Should differential treatment of age groups be viewed in the same way?

According to Daniels, bias against age groups is different from bias against other groups, and in fact may not be an evil. This conclusion can be made to seem reasonable, he holds, if we approach the problem of "age bias" as one of individual rationality rather than of justice. Daniels calls our attention to the fact that distribution of health resources between stages of life is, or can be seen as, a problem for the individual just as for society. It is not at all obvious how a prudent individual might decide to allocate a given quantity of health resources over the course of his own life, even with good information about his future needs. Daniels holds that if we can determine that a certain solution or range of solutions is prudentially optimal for one individual, we will have gone much of the way toward

achieving a reasoned solution of the problem of intergenerational competition for resources in society as a whole.

Not surprisingly, given the nature of his theory of distributive justice in health care delivery, Daniels believes that the prudent individual would be especially concerned with opportunity. Though new careers and social mobility may be unlikely at an advanced age, there are still decisions to be made regarding life plans. There will still be an age-relative set of opportunities from which the individual can choose. We each have an interest in having the choice of a wide range of these plans, according to Daniels, and we also want to preserve the ability to revise our choices. We simply do not know when we are young what our tastes and values will be when we are old, and we want to retain the freedom to build our lives according to whatever preferences we will have in old age. To the extent that health care is necessary to preserve these opportunities, we will want to allocate health care resources to that phase of our lives. Because resources are scarce, we will have to skimp a bit more than we might like on health care during earlier stages. There will, however, be limits; we want especially to ensure that we will live long enough to be old. The individual will, then, countenance certain economies in the health care he will receive in later years.

An age cutoff or other differential treatment of the elderly is not an instance of bias, according to Daniels, if it is the result of a choice an individual would have made *for his own case* in allocating health resources over his own lifetime. Thus, we may proceed to reason our way to a defensible allocation of health services to the elderly, unburdened by unwarranted fear of engaging in age bias.

Daniels's approach should not be regarded as endorsing the wholesale abandonment of the elderly, however. To the extent that the elderly as a group coincide with the poor, there may be other requirements of justice that may be met only by channeling resources to the elderly. Some of the allocation decisions regarding an individual's life stages may be undecidable in abstraction from the circumstances of one's life, and therefore not amenable to solutions by Daniels's method. And Daniels reasons, as has been said, that the representative individual does have a natural interest in providing for health care for his older self, since he will be concerned to preserve a range of opportunities.

Liberty. In 1971, the *NEW ENGLAND JOURNAL OF MEDICINE* carried an article by a libertarian physician, Robert Sade, which stated that

The concept of medical care as the patient's right is immoral because it denies the most fundamental of all rights, that of a man to his own life and the freedom of action to support it. Medical care is neither a right nor a

privilege: it is a service that is provided by doctors and others to people who wish to purchase it. It is the provision of this service that a doctor depends upon for his livelihood, and is his means of supporting his own life. If the right to health care belongs to the patient, he starts out owning the service of a doctor without the necessity of either earning them or receiving them as a gift from the only man who has the right to give them: the doctor himself.

According to Sade, then, any government effort to assure access to medical care would violate the fundamental moral rights of doctors. This is one way in which universal access to health care is said to be incompatible with individual liberty. A second conflict, much stressed by organized medicine in its long battle against government intervention in the market for health services, is the one between universal access and certain liberties of patients, such as the liberty to choose one's own health care. Together, these have been presented as evidence of the unsuitability of governmental health programs in a free society.

Dan Brock's essay, *Distribution of Health Care and Individual Liberty* (Appendix J) provides an analysis of these claims and considers several replies that have been or could be made. One is that the market for health services is not very responsive to individual needs and preferences, and hence that the primary justification for a free market is weak.⁷ The case for this claim is familiar. A second reply takes the discussion from the level of principal to that of policy: It is simply a fact that governmental programs to assure access to health care can and do permit the patient to choose his or her doctor. Furthermore, patients are always free to ignore the entitlements bestowed by government and so to make any choice the market allows.

The third reply is the most fundamental: that the liberties of which Sade spoke are not matters of right. A governmental program that provided the means of access to health care, and even one that supplied facilities and medical staff, would violate liberties to no greater extent than does public education or the governmental's postal service. Brock grants that a ban on private medicine would raise serious questions about liberty; but no such proposals are, or have been, in contention.

There is indeed an argument concerning liberty that bears on current proposals to assure access to health care: the libertarian objection to *all* programs that impose taxes to help the needy. The liberties figuring in this argument, however, are those of taxpayers. This objection is obviously different from Sade's complaint. It is clear that the doctor or other health

⁷ Peter Singer (1976) argues that the existence of a market makes certain goods unattainable at any price. See also above subsection titled "Why Should Health Care Be Distributed Differently?"

professional might suffer a loss of power in the market for health services were the government to provide free health services. But unless we accept the libertarian's ban on all such governmental involvement, it seems reasonable to conclude that it is the doctor's interests, not his or her rights, that would be threatened.

Desert. As we have seen, Rawls denied and Gauthier affirmed that those who prosper as a result of their natural talents deserve to do so. Rawls gives the notion of desert no basic role in his theory of justice; in Gauthier's rival theory, desert figures prominently. George Sher, in his essay *Health Care and the "Deserving Poor"* (Appendix L), demonstrates that the concept of desert also is involved in the debate over access to health care.

There are two reasons for thinking that equity in access to health care might vary with individual desert. First, a person might be unable to purchase care because he had imprudently squandered his funds on other goods. Thus, had the person acted more responsibly, he would have been able to pay his own bills. Some would hold that he therefore does not deserve to be assured of access to health care. Second, a person might cause himself to become sick by taking risks with his health. His need was avoidable; had he acted more prudently, he would not have needed help in purchasing health services. Again, some would insist that this person does not deserve to be given access to health care. The first of these propositions seems to have been historically important in shaping Federal welfare policies, and therefore in determining who would be benefited by Medicaid. The second proposition has been the subject of an animated debate during the last decade, but it has not yet been put into effect in any major way. [Evans, 1982; U.S.D.H.E.W., 1979; Wikler, 1978.]

As Sher notes, each of these claims makes sense only against a background assumption that those who are ill and unable to pay for health care ordinarily ought to be given assistance. The grounds for this claim are to be found in a theory of distributive justice in health care delivery, and not, according to Sher, because the indigent sick have (necessarily) done anything to deserve care. In this sense, the "deserving poor" or the "deserving sick" are not really deserving. They stand out, however, and are assisted, because they are "not undeserving." According to Sher, the imprudence of those who are undeserving sets limits on what might come their way under the terms of a theory of distributive justice. Treatment of those who could have chosen to be affluent or healthy would be a matter of charity rather than of justice, if these views of desert were accepted.

Sher does not dismiss the possibility that the notion of desert might be a proper basis for distributing health services.

In his view, the proposal makes sense in the abstract. For example, to brand an imprudent person as undeserving is to evince a strong respect for that same individual's freedom of choice.

However, the distinction between deserving and undeserving does not provide simple criteria for determining who should have access to care. Infants and the totally disabled are obviously not undeserving, since they are not in a position to make choices that would render them healthy or wealthy enough to pay their own bills. The able-bodied, however, may be a mixed lot. Some do not have job opportunities; others, because of adverse social or psychological conditions, "cannot adequately manage their own lives." Determining who ought to have access to health care, then, would require a determination of which individuals are in a position to make real choices. Even with data of this sort in hand, however, Sher reminds us of "our common desire to temper justice with mercy—to provide aid to persons in desperate straits regardless of what they deserve."

Conclusions

The philosophical essays surveyed in this introduction address a host of questions that arise in consideration of equity in access to health care: Who should receive care? Who should pay? Whose ailments may be left untreated? What other rights must be respected in any effort to remedy inequities?

It would be an effective advertisement for the profession of philosophy, and a boon to policymakers, if the philosophical essays on health care delivery spelled out in certain and unequivocal terms which policies would be right and just and which would be wrong. The essays published here and elsewhere, however, do not invariably succeed in eliminating moral uncertainty. The resolution of moral quandries requires much empirical data, and this cannot be deduced from philosophical axioms. Moreover, philosophers writing on access to health care have shown as much interest in tracing standards of equity back to their roots in moral philosophy as they have in following them forward to any implications for actual policy.

For these reasons, neither the philosophical work sponsored by the Commission nor that already in the literature can be said to furnish a blueprint for a just health care system. But there are benefits all the same.

The essays amply demonstrate that empirical data, however crucial to developing standards of equity, do not suffice to settle the moral issues. A great deal of the moral uncertainty is due to *philosophical* uncertainty, resolution of which is required if the significance of the empirical evidence is to be determined.

The recourse to moral theory, for all the intellectual complexity it introduces, has a similar kind of salutary effect. We are warned not to persist in the hope that any simple moral principle, and certainly no slogan, will provide an adequate solution to the equity dilemmas. As the theoretical papers show, our moral beliefs concerning equity in access to health care have numerous connections with our beliefs about the just society in general. Many of the outstanding issues are common to both subjects. Given the wide diversity of opinion over social justice, it is hardly surprising that there are numerous, distinct views of what constitute appropriate standards for equity in health care delivery.

Nevertheless, it would be overly cautious to conclude that these philosophical essays offer only insight and no advice. It is true that each essay provides a different account of equity in access to health care and insists that rival accounts are mistaken. Yet there is one policy recommendation supported by each of these essays: Every person ought to be assured of access to some decent minimum of health care services. This conclusion cannot be said to have been "proved" by this collection of arguments, but the fact that a recommendation of universal access to (at least some) health care follows from such disparate sets of premises suggests that the recommendation is "insensitive" to choice of moral theory. Even if we do not know which moral theory is correct, then, and thus cannot provide a ground-level-up proof that all should have access to a minimum of health care, such a belief has been rendered reasonable and perhaps even compelling. In this sense, this diverse and inconsistent collection of theories of justice in health care delivery supports the consensus reached by members of the President's Commission concerning the moral obligation of our society to ensure access to health care for all its people. That these essays do so while putting much emphasis on the justification of limits to care may further buttress the Commission's effort to speak of equity in access in an era in which other kinds of policy concerns hold center stage.

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The Prospective Pareto Principle and Equity of Access to Health Care

G

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“**M**ORALITY IS MADE FOR MAN, NOT MAN FOR morality.”¹ I interpret this aphorism as suggesting that questions of morality can most fundamentally be addressed by considering human benefits and human harms—those benefits and harms to which our acceptance of various alternative moral principles would tend to lead. This formula is vague, but I shall be concerned in this paper with one attempt to state clearly at least a part of what is involved.

I shall be examining issues of social justice in access to health care. Does justice, I shall ask, require that everyone be assured access to every kind of health care that can be expected to benefit him? If not, does it at least demand that everyone have equal access to health care, without regard to income or place of residence? Or does justice rather demand no more, and no less, than that everyone be assured a “decent minimum” of access to health care—and if that is so, what comprises that “decent minimum”?

These questions of social justice are at basis questions about our responsibilities to each other. They bear on issues of public policy, at least in part because government programs often serve as the means of carrying out our responsibilities—or what many take to be the responsibilities of a person to his fellows. A system of social insurance

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¹ The allusion is to MARK 2:27. This aphorism has been a theme in the moral philosophy of William Frankena, ETHICS (Englewood Cliffs, N.J.: Prentice-Hall, 1963), p. 37.

may discharge the responsibility that each person has to aid those in distress, and a system of retirement income may discharge an individual's responsibility to support aged parents. It might seem, then, that when a set of individual responsibilities can most effectively, reliably, and economically be carried out through the powers of government, then one way, and perhaps even the best way, that a person can act to discharge his moral responsibilities is successfully to support relevant legislation—legislation that charges the government to see to it that those responsibilities are met.

This raises serious and controversial ethical questions. In the first place, it is controversial whether and to what degree each person has a general responsibility to aid others in distress. In the second place, it is controversial in what ways it is even legitimate to harness the coercive powers of government to the task of meeting our responsibilities to each other. Governmental power is coercive; taxes are collected and legal duties and prohibitions are enforced by coercion when other means fail. The coercive powers of government are notoriously used in immoral ways by tyrants, and it is a matter of controversy within what limits governmental coercion can be morally legitimate. Ethical issues, then, lie at the heart of disputes over the ways government should and should not act, through legislation and executive organization, to see to it that our needs are satisfied and our moral responsibilities to each other are fulfilled. We may call these problems of *social ethics*.²

Disputes over questions of social ethics may be rooted in basic ethical disagreement, but they need not be (Stevenson, 1944: chaps. 1–2). Where there is disagreement as to what policies should be adopted, the basis may be disagreement as to what the effects of alternative social policies are likely to be. If one person favors active governmental programs to ensure good medical care to all at a low price and another favors “letting the market decide,” their dispute may be rooted in disagreement about the kind of medical care that the poor will receive under the one system and under the other, or over the long-term effects on motivation and economic production of governmental preemption of the market.

Such a dispute may, on the other hand, be rooted in disagreement that is more fundamentally ethical. There may be various advantages and disadvantages to each of the two systems: gains and losses in legal

² One could try to draw a sharp distinction between ethics, morality, and justice, but I shall be using the terms as roughly interchangeable. When we inquire into these realms, I take it we are trying to find a basis for deciding how to live with each other and what to demand of each other. A classical attempt to say what is distinctive about “morality” and “justice” is found in chapter 5 of John Stuart Mill, *Utilitarianism* (1863).

freedom of choice, gains and losses in the effective freedom of choice that various peoples' incomes allow, gains and losses in the quality of medical care that various people get. The two disputants may agree on what those advantages and disadvantages are. They may even agree, all things considered, that some people are better off with one system and some are better off with the other. They may agree on who gains what and who loses what with each system, and yet disagree on the ethical import of the pattern of gains and losses. If one scheme delivers better care to the poor than the other but severely restricts the freedom of doctors, is it to be preferred? If the disputants agree on the non-ethical facts but have opposing views on the ethical import of that array of facts, then their disagreement is over matters of fundamental ethical principle.

In many realms of life, no doubt, satisfactory ethical judgments can be made without careful analyses of the fundamental bases of these judgments. That is unlikely to be the case, however, with questions of health policy. When applied to those questions, whatever "moral good sense" we may develop in the ordinary course of life is likely to be inadequate. The effects of health policy are immensely complex, and so we cannot simply take in the nature and the effects of a set of policies at a glance and focus our moral good sense on them. It is, of course, difficult and often impossible to establish reliably what the effects of a proposed policy will be, but even when we can it remains to be said which features of the policy and its effects are desirable, which are undesirable, and how the desirable and undesirable aspects balance from an ethical point of view. The effects of a policy will involve many people in profound ways. Any adequate description of these effects will be statistical, whereas common-sense moral judgments have been trained on simpler circumstances more vividly presented (Nisbett and Ross, 1980). To make well-founded moral judgments on the basis of sophisticated analyses of the effects of policy, we shall need sophisticated ethical theory. We shall need to work out explicitly the kinds of ethical considerations we think should govern, and the weights these considerations should have.

How can problems of social ethics be addressed? How, for example, can we establish whether the claims I made earlier about our "responsibilities" to each other are warranted? Must our answers to questions of social ethics be mere expressions of prejudice, or a matter of unquestioning adherence to the prevailing moral opinions of our day—moral opinions that later ages may find repugnant? These fundamental questions on the nature of rational moral deliberation remain matters of controversy among ethical theorists (Brandt, 1959, chap. 10; Brandt, 1979, chaps. 1, 10; Hare, 1963, 1981; Rawls, 1971, sec. 9), and I shall not try to answer them at all fully in these introductory remarks. I do want to claim that three widespread modes

of approach will not do. In the first place, it will not do simply to test putative ethical principles by our "ethical intuitions." Whatever validity such intuitions may have in daily life, they clearly have not been formed in response to all the complexities raised by issues of health care policy. In the second place, it will not do to confine ourselves to discovering what pertinent values are actually held in our society. Our value commitments are not immutable, and in the face of novel circumstances produced by advances in medicine, we need to develop and refine the values and ethical principles to which we adhere. We need to do so in a thoughtful, reflective way, as fully cognizant as possible of relevant considerations. Finally, it will not do simply to "let the political process decide." We are all part of the "political process," and we need to decide how to use whatever political influence we have. Conscientious choices in these matters must be informed by ethical judgments.

How, then, can we address fundamental ethical questions involved in issues of health care policy? What I shall do in this paper is not to take up this general question, which is, after all, the central, controversial question of moral philosophy. I shall rather examine an attempt to skirt this question and yet answer many of the ethical questions central to health care policy. I shall start with the aphorism, "Morality is made for man, not man for morality," and consider an attempt to work out a part of the content of that aphorism. The aphorism invites us to address ethical questions by considering human benefits and harms. The principle I shall examine—called the *Prospective Pareto Principle* or the *Ex Ante Pareto Principle*—applies to situations in which, in a sense to be explained, all considerations of benefit and harm can be resolved so as to "speak with one voice."

Let us begin with a more modest principle, the *Simple Pareto Principle*, as a standard for evaluating policies.³ A given person may be benefited by a given policy in some ways and harmed by it in other ways. We may speak, though, of how he is affected *on balance* by the policy—of whether, on balance, he is benefited or harmed. If some people benefit on balance from a policy and some, on balance, are

³ The Simple Pareto Principle (or, simply, the "Pareto Principle") is due to Vilfredo Pareto, *Manuel d'économie politique* (Paris: Girard et Briere, 1909). Pareto developed an elaborate theory of the basis for impartial moral judgments, but the Pareto Principle is now ubiquitous in theoretical welfare economics, quite divorced from its original context. What I am calling the Ex Ante Pareto Principle may be due to K.J. Arrow, *Le rôle des valeurs boursières pour la répartition la meilleure des risques*, *Econometrie: colloques internationaux du centre national de la recherche scientifique* 11 (1953): 41–47, and the "straightforward applications" of it, except in the respects to be noted, are of a kind fairly standard in writings of theoretical welfare economists.

harméd by it, that may raise difficult issues of welfare and equity. Suppose, though, that no one is harmed on balance and at least some are benefited. Then assessment of the policy is especially unproblematical. If ethical questions are to be addressed in terms of benefits and harms, then, it would seem that a policy that benefits someone on balance and that harms no one on balance is a good policy, from an ethical point of view. That, in rough form, is the Simple Pareto Principle.

Turn now to the *Prospective* or *Ex Ante Pareto Principle*. Think of life as a gamble, or rather a series of choices among gambles. We do not know when or in what ways we shall be ill, and when we are ill, we do not know, for sure, what various kinds of medical care will do for us. At the same time, we have some rough ideas of our chances and what we can do to affect them. Government policy helps to determine which "gambles" are open to us to select. If, for instance, there is compulsory medical insurance, then a person cannot choose to save his premium and risk the consequences. We can speak, then, of the prospects a person has under a policy—the gambles with which he would be faced or which he would choose to face if that policy were adopted. Now some prospects are more desirable than others; most people, for instance, would find the prospect of playing Russian roulette less desirable than the prospect of losing \$5.00. Policy choices affect the distribution of prospects; if we tax the rich to provide medical care for the poor, that betters the prospects of the poor and worsens the prospects of the rich (further economic ramifications aside). In this case, we might say, there are opposed prospective interests.

The Ex Ante Pareto Principle is an ethical principle that applies only to those special cases where there are no opposed interests in prospect. It is thus quite narrow in its scope, and covers only those cases that seem least problematical, morally speaking. The principle says, in effect, that where prospective interests are unopposed, they should prevail. More precisely, let P and Q be alternative policies. Then, the principle says, if both 1) the prospects of at least one person are better under P than under Q , and 2) no one's prospects are better under Q than under P , then ethically speaking, P is better than Q .

An advantage of the Ex Ante Pareto Principle is that it seems to make a very modest claim. It seems to say, in effect, that where in prospect there is reason to prefer P to Q and no reason to prefer Q to P , then P is preferable. The principle does rest on a conception of what, ethically speaking, constitutes a reason for preferring one policy to another; a consideration favors P over Q from a moral point of view only by tending to make someone's prospects better under P than under Q . That, however, should be acceptable to anyone who accepts that morality should serve humanity, that morality is made for man and not man for morality.

Now, although the Ex Ante Pareto Principle seems to commit us only to what is most unquestionable in ethical theory, it turns out to have extensive implications for health care policy, as I shall explain in later sections of this paper. It follows from the principle that except under special circumstances, there is no moral right to equal availability of health care, unless there is a moral right to full economic equality in general. It follows that if a treatment is sufficiently expensive, it should be withheld even if it is the most effective treatment for a grave ailment. More carefully put, what I shall be showing is that if the principle is granted, then good cases can be made for these conclusions. In the final section, I shall briefly inquire whether the straightforward applications of the principle that I sketch leave out important considerations, and whether their conclusions discredit the Ex Ante Pareto Principle.

The Simple Pareto Principle and Its Sparse Implications

The Ex Ante Pareto Principle, as I have said, is an extension of the Simple or Ex Post Pareto Principle. The difference is that what the Ex Ante Principle says of "prospects," the Ex Post Principle says of "outcomes." Let *A* and *B* be two economic states. If, the principle says, someone is better off in state *A* than in state *B* and no one is better off in state *B* than in state *A*, then state *A* is, ethically speaking, better. The Simple Pareto Principle is especially weak in that it tells us how to compare the worth of two economic states only in rare cases: those cases in which no individual interests are opposed to each other. Normally, we face choices with respect to which individual interests are opposed: between states with some people better off in one and some better off in the other. For these choices, the Simple Pareto Principle tells us nothing.

The Simple Pareto Principle merits further comment and elucidation. In the first place, the principle is sometimes expressed as a standard for evaluating changes, but that is misleading. If a change makes at least one person better off and makes no one worse off, it is said, then the change is an improvement, ethically speaking. We need ethical principles in matters of public policy, however, in order to compare alternative policies for the same period—say, the effects of alternative tax schedules that might be enacted, or of alternative combinations of laws and regulations affecting the organization of health care. An "economic state," in the sense of the principle, should be understood as an entire, detailed history—often the history of what would happen were some particular set of policies to be adopted.

In the second place, the principle is often put in terms of preferences: If someone prefers *A* to *B* and no one prefers *B* to *A*, then *A* is better than *B*. Here I have used the language "is better off in *A* than in *B*" and not said anything about what constitutes being "better off." I shall discuss this matter later, in connection with the more elaborate Ex Ante Pareto Principle; here let it be noted that nothing I have said presupposes that a person is always "better off" in whichever state he prefers.

In the third place, much has been made, in economists' use of the Pareto Principle, of "Pareto optimality" or "Pareto efficiency," but even if the Pareto Principle is valid, Pareto optimality is a weak recommendation from the ethical point of view. The relevant definitions can be put as follows. Let *A* and *B* be two "economic states": detailed possible histories. *A* is said to be *Pareto-superior* to *B* if and only if at least one person is better off in *A* than in *B* and no one is better off in *B* than in *A*. The Pareto Principle, then, is that *if a state A is Pareto-superior to a state B, then A is better than B from an ethical point of view*. An "economic state" may be technologically infeasible, in the sense that no matter what people decided to do, the sequence of events that constitutes that state would not come about. It is presumed technologically infeasible, for instance, for everyone in the world to attain the present median American standard of living by the year 1985. An economic state is defined as Pareto optimal if, and only if, it is technologically feasible and no technologically feasible state is Pareto-superior to it. Now if the Pareto Principle is a valid ethical principle, then Pareto optimality has some ethical implications. It follows that 1) any technologically feasible state that is best, ethically speaking, is Pareto optimal. For were such a state not Pareto optimal, that would mean, by definition, that some technologically feasible state were Pareto-superior to it, and hence better—this last by the Pareto Principle. Equivalently, 2) any state that is not Pareto optimal fails to be the best technologically feasible state. These properties, though, give policy makers no ethical grounds for seeking Pareto optimality. The policy makers' choices are confined, at the very least, to states that are economically feasible: states that could be made actual by government policy. (Here I interpret "economics" as "political economy" in the original sense, as the political analog of the art of running a household, and hence the study of government economic policy and its effects.) Government cannot legislate universal sainthood or enlightened single-minded devotion to social justice on the part of all economic agents; it can do such things as adjusting tax incentives, affecting the money supply, promulgating and enforcing prohibitions, attempting directly to control wages and prices, establishing organizations to provide services, and the like,

and perhaps have a substantial influence on economic agents by means of moral suasion. Now, since few technologically feasible states are economically feasible, the best economically feasible state may well not be the best technologically feasible state, and hence may well not be Pareto optimal.

The following would be fallacious inferences from the Pareto Principle:

P-fallacy 1. At least one best economically feasible state is Pareto optimal.

P-fallacy 2. If a state *A* is Pareto optimal, and a state *B* is technologically feasible but not Pareto optimal, then *A* is better than *B*.

We have already seen why *P-fallacy 1* would be a fallacious inference from the Pareto Principle. To see that *P-fallacy 2* would be so as well, note that the ethical standard given by utilitarianism is in accord with the Pareto Principle. Suppose it is meaningful to speak quantitatively of how well off a person is in a state; call that quantity his *welfare* in that state. Utilitarianism says that the value, ethically speaking, of a state is the sum of all individuals' welfares in that state. Utilitarianism, then, entails the Pareto Principle, and hence the Pareto Principle can entail nothing at odds with utilitarianism. Now suppose, for the sake of simplicity, there are only two people, *i* and *j*, and that within the limits of technological feasibility, if *i*'s welfare is 10 units then *j*'s welfare can at most be 1 unit, whereas if *i*'s welfare is 7 units then *j*'s can be 6. Then welfare distributions 10,1 and 7,6 are both Pareto optimal (where 10,1, e.g., means 10 to *i* and 1 to *j*). 6,6 is better, according to utilitarianism, than 10,1, since it gives total welfare of 12 as opposed to 11. Yet 6,6 is not Pareto optimal, since 7,6 is Pareto-superior to it.

The Simple Pareto Principle, then, has few implications for government policy, taken by itself. It does not follow from the Pareto Principle that governmental policy should be designed to achieve Pareto optimality, alone or among other goals. It does not follow from the Pareto Principle that government should let matters be settled by a free market, or that freedom of contract should not be abridged—even if it can be shown that a free market can achieve Pareto optimality.

The Simple Pareto Principle may have some more substantial implications in combination with the results of economic theory. In particular, the two "Fundamental Theorems of Welfare Economics" say things about the Pareto optimality of free markets under certain highly idealized conditions (Varian, 1975: 228–235). The first says that, under those conditions, free competition is Pareto optimal. For the reasons given, that is of little ethical interest. The second is much

more significant. It says that, under the idealized conditions of the two theorems, any technologically feasible state can be ensured by free competition and an aptly chosen lump-sum distribution of initial endowments. That seems to say that any technologically feasible state is economically feasible. If that is so, then from that and the Simple Pareto Principle, it follows that the best economically feasible state is Pareto optimal, and so the government should, among other things, try to ensure Pareto optimality.

There are two reasons, however, why that conclusion cannot be drawn from general facts about the world and the formal validity of the second "Fundamental Theorem of Welfare Economics." First, the idealization of the theorem's assumptions is extreme, especially when there is a large degree of uncertainty. Second, even given the idealized assumptions of the theorem, the government, to achieve a particular "best" Pareto-optimal economic state, would have to be omniscient about the details of individual preferences and abilities. It may not be able to achieve anything close to the best technologically feasible outcome merely with general knowledge of the kinds of abilities and preferences people are likely to have.

The Ex Ante Pareto Principle

Issues in health care, it has often been noted, are characterized by extreme uncertainty as to the effects of the policy on particular individuals. No one, including the person himself, knows what health care he will need and what that health care will do for him. It is this extreme uncertainty that makes the Simple Pareto Principle especially unhelpful as a guide to health care policy.

When, however, the Pareto Principle is extended from "states" to the chancy prospects that people face in life, it turns out to be rich in its implications—as I shall indicate in the next three sections. The interests different people have are much less likely to be opposed to each other in prospect than in retrospect; that is why it is often crucial, for the sake of peace, to settle the rules of the game in advance of playing it. Even when extended to prospects, to be sure, the Pareto Principle is far from providing a fundamental basis for answering every question in the ethics of health care. It is insufficient, even, once the facts of economics, psychology, and medical science are known. Still, the principle will tell us important things about such issues as the ethics of cost-containment policy and the purported right to equal health care. The extended principle, then, needs to be examined seriously.

What the Simple, Ex Post Pareto Principle says about the outcomes of social policies as they affect various individuals, the Ex Ante Pareto

Principle says about the chancy prospects individuals face as a result of policy choices. A grossly oversimplified sketch of life will illustrate how policies may affect prospects. Suppose all that matters to us in a given month is whether we are well, sick, or dead, and how much money we have. Suppose that whenever we are sick, we recover or die, and our chances of recovering depend on whether we receive health care or not. Suppose, in particular, that 10 percent of us get sick, and of those who do, 30 percent (the resilient sick) recover whether or not they get medical care, 50 percent (the doomed) die whether or not they get medical care, and the other 20 percent (the critical) live if they get medical treatment and die if they do not. When a person gets sick, he does not know whether he is resilient, critical, or doomed. But governmental policies may leave open two kinds of choices: 1) a person may have the choice, before he knows whether he is sick or well, of buying insurance; and 2) when a person gets sick, he may have the choice of whether or not to get treatment. Governmental policy, among other things, will determine what choices he has and what the alternatives will cost the individual. Table 1 shows the prospects for life that a person faces before learning whether he will be sick: 1) if he commits himself at the outset to be treated if sick, or 2) if he commits himself not to be treated if sick. The relevant probabilities are calculated from the outcomes of the two policies in the four possible cases.

Suppose that a person can choose whether to buy insurance and whether to be treated if sick. Four policies are then open to him, as shown in Table 2 (although the fourth policy has nothing to recommend it). Table 2 also shows the outcomes of these policies and their probabilities, if insurance costs \$200 and treatment costs \$1,000 for the uninsured. Outcomes are shown as amounts of money paid if alive; it is assumed that no one cares how much money he has if dead. Thus a person who would buy insurance and get treatment if sick faces a prospect: pay \$200 with probability .95, die with probability .05. Suppose that were insurance not available, competition would bring the price of treatment down to \$600, but that the person

TABLE 1
Prospects for Life Faced by a Person Before Learning Whether He
Will Be Sick

Strategies	Probabilities of Initial States Outcomes Given Initial States				Outcome Probabilities	
	Well (.90)	Resilient (.03)	Critical (.02)	Doomed (.05)	Alive	Dead
Treat if sick	Alive	Alive	Alive	Dead	.95	.05
Don't treat	Alive	Alive	Dead	Dead	.93	.07

TABLE 2
Prospects of a Person Choosing or Not Choosing To Buy Insurance

Strategies	Probabilities of Outcomes				Outcomes Given Initial States			
	0	-\$200	-\$1,000	Dead	Well (.90)	Resilient (.03)	Critical (.02)	Doomed (.05)
Don't insure, but treat	.90	—	.05	.05	0	-\$1,000	-\$1,000	Dead
Don't insure, don't treat	.93	—	—	.07	0	0	Dead	Dead
Insure and treat	—	.95	—	.05	-\$200	-\$200	-\$200	Dead
Insure, but don't treat	—	.93	—	.07	-\$200	-\$200	Dead	Dead

would not seek treatment if sick and uninsured, even at that price. Then a policy of forbidding insurance in order to increase price competition would face the person with a prospect: pay nothing with probability .93, die with probability .07. On the other hand, for a person who would seek treatment even if it cost \$600, a policy of forbidding insurance would yield a prospect: pay nothing with probability .90, pay \$600 with probability .05, and die with probability .05.

In effect, then, a social policy assigns a prospect to each person, which we may call his prospect under that policy. The Ex Ante Pareto Principle says this: given two policies, *P* and *Q*, if each person's prospect under *P* is at least as desirable as his prospect under *Q*, and someone's prospect under *P* is more desirable than his prospect under *Q*, then *P* is, ethically speaking, a better policy than *Q*.

The principle, so put, will need some elucidation and interpretation. First, what makes one prospect more desirable for a person than an alternative prospect? A standard economist's answer is that the more desirable prospect is the one the person would choose if given the choice. That answer seems unsatisfactory for at least three reasons. In the first place, what a person would choose indicates desirability only if the person is imagined to be choosing in full light of all the available information. A choice, to be a reliable indicator of desirability, must be made with full realization of what it would be like to live out the various alternatives at issue, and what the probabilities in question really mean. Now if we want ethical guidance on the details of health policy, we shall need to deal with a multitude of complex issues, and no one can reasonably be expected to think all these issues out for himself. Few people, no doubt, have looked seriously into such expensive treatments as renal dialysis, and learned what their chances of needing it are and what it would be like to undergo the treatment, or to need it and to be unable to afford it. Judgments of probabilities and desirabilities in these matters require expertise. In the second place, a person may prefer one alternative to another not because he thinks it makes his own prospects more desirable, but because he thinks it makes the prospects of many others more desirable, and he is either altruistic or guided by moral principles that he accepts. In that case, what he prefers will not be a reliable guide to what he thinks offers the best prospects to himself. In the third place, a person may choose among prospects for himself not only on the basis of how desirable he finds those prospects, but on the basis of how desirable he finds the risk of being responsible for bad outcomes. People apparently find it much worse to be responsible for suffering a loss than to suffer the same loss unavoidably.⁴ When

⁴ This is indicated by recent work of Amos Tversky, not yet published.

these principles affect a person's choices among risky prospects, then what the choices reveal is at most which prospect the person prefers to *choose*, not which prospect he prefers to face if he is not responsible for the choice.

Here I shall treat the desirability of a prospect for a person simply as something that we understand. Desirability is a matter of preferability from a prudential point of view—a point of view concerned solely with how intrinsically rewarding it is to the person himself to lead the life he does. If we can reduce ethical questions to questions of prudence or self-interest, then we shall have made progress. It seems easier to judge what kind of life is most worth experiencing than to judge the ethical questions that most trouble us. The ease, of course, is only relative; it may be even easier simply to observe what people choose. If I am right, though, it is not what a person chooses that matters most directly for ethics, but what is prospectively best for him.

According to the Ex Ante Pareto Principle, then, we may settle at least some questions of social ethics as follows. Given a choice between two policies, we ask for each affected person: "What prospects for an intrinsically rewarding life does each policy present him?"; "Which policy is the better one, simply in terms of how desirable it leaves his prospects in life?" If the answer is the same for each person, then the policy that gives each person a better prospect is Pareto-superior ex ante, and hence, according to the Ex Ante Pareto Principle, the better policy ethically speaking. If the answer differs from person to person, the Ex Ante Pareto Principle offers no moral guidance.

Applications: Extraordinarily Expensive Treatments

What constitutes just or equitable access to health care? There is an answer that is sometimes accepted as so obvious as to need no comment. What justice requires, it is often supposed, is that every person have available to him the best health care that could possibly be provided, given the current state of medical knowledge.

However, if the Ex Ante Pareto Principle is valid, then justice cannot demand so much—or so I shall argue in this section. In this and the following two sections, I should stress, I shall not be asking whether the Ex Ante Pareto Principle indeed is valid. That will come later. Rather, I shall be examining the kinds of ethical conclusions that can be drawn from the principle, on the assumption that it is valid. The conclusions here will not follow deductively from the principle taken alone; they are conclusions, rather, in that they follow

from the principle in combination with what, I take it, we know about the human condition in a society like ours—a moderately wealthy society, capable of high medical technology.

Does justice or equity, then, require that everyone receive the finest medical care that money can buy? In so unqualified a form, the claim seems thoughtless. In the first place, it might be technologically infeasible to provide everyone with the best medical care that could be provided to anyone. Resources may be too scarce. If a kind of treatment draws extensively on scarce resources, then although it may be that the resources of a society are sufficient for such treatment to be provided to a few, the resources of that society, or indeed of the world, are insufficient for the treatment to be provided to all. Equity cannot require the impossible, and if the demands of equity are demands on governmental policy alone, then they cannot require what is economically infeasible.

A more modest version of the demand that all receive the best is this: If it is economically feasible for all to receive the best care known to medical science, then equity demands that such care be provided to all. In this formulation, the principle is quite narrow, in that it says nothing about what equity demands when “the best known treatment for all” is economically infeasible. Before we examine the demand even in this narrow version, though, a further revision is needed. Some health care discussions address conditions that are not serious—conditions that do not threaten life and do not threaten to become debilitating. That all must receive the best feasible health care seems most plausible in questions of life or death, or questions of serious impairment. Can we at least say this: If it is economically feasible for all to receive the best care known to medical science, then at least when life itself is at stake, or when care may prevent serious, long-term debilitation, equity demands that all receive the best care known to medical science.

I take equity here simply to mean acceptability from an ethical point of view. A virtue of the *Ex Ante* Pareto Principle is that it transforms some questions of equity into questions of prudence under conditions of risk; questions of equity in retrospect become questions of unanimous prudence in prospect.

There is a limit to what it is rational to pay to avoid risks of catastrophe. When one crosses a busy street, one runs a small risk of death or crippling injury, usually for a small gain; but if one crosses prudently, the small likely gain, all of us seem to think, outweighs the risk of catastrophe. Suppose, then, that certain life-saving medical treatments are extraordinarily expensive. If a person faced a private choice of whether to insure against the need for such treatment, his choice would be, in effect, one of whether to accept the risk of needing

expensive medical treatment and not being insured for it, for the small benefit of saving on the insurance premium to buy something else. If the treatment is sufficiently expensive and the chances of needing it are small, then the prospect of going uninsured may be the more desirable one, prudentially speaking. That may be so for the same reason as the prospect of crossing a street is often more desirable than the alternatives, despite a small risk to life and limb. Just as there is a limit to what it is rational to pay, on prudential grounds, to avoid other risks, there is a limit to how much it would be rational for an individual to pay for a guarantee of whatever expensive, vital health care he might turn out to need.

In the first place, of course, some medical care is of no benefit to a person whatsoever; it is hard, for instance, to see why anyone should want to be kept alive if he should fall into an irreversible coma, and it would be unreasonable to sacrifice an iota for an assurance that one would be kept alive in that eventuality. Other assurances of expensive treatment may be worth something, but not as much as the assurances themselves would cost. A possible example is the assurance that kidney dialysis will be available if needed. It may be a better prospect—rationally to be preferred, that is, on prudential grounds—to enjoy what the premium will buy if one is healthy and risk needing the treatment and not being able to get it, than to live less well if healthy and get the treatment if one needs it.

Whether an assurance is worth its price is a matter of the risk of needing the treatment, the value of the treatment if it is needed, and the cost of the assurance. The social cost of the assurance will be a matter of the risk of the disease and the resources diverted to treatment from other uses to which they might be put. What the assurance costs a given person, in comparison to a specific alternative economic arrangement without that assurance, is a matter of how the social cost of the assurance is distributed. The import of the Ex Ante Pareto Principle is this. Suppose a scheme is proposed for assuring and financing an expensive kind of medical care. Suppose the cost is distributed in such a way that each person, in advance of knowing whether he will need that kind of care, faces a worse prospect on balance given the scheme and his share of its cost than he would face without the scheme and keeping his share of the cost. Then it is better, ethically speaking, not to have the scheme. True, those who turn out to need the care are, as it turns out, substantially worse off without the scheme than with it. On the other hand, the many who do not need the care are better off having their share of the cost to spend on other things. These are the considerations that need to be weighed against each other, and the test by desirability of individual prospects shows us how, from an ethical point of view, they balance out.

There must be a limit, then, to what we ought, from an ethical point of view, to be willing to pay for life-saving treatment. More precisely, if the Ex Ante Pareto Principle is valid, then there are ways of allocating economic burdens that are so onerous that it would be better, ethically speaking, for no one to receive certain kinds of life-saving treatment, than for the burdens to be imposed and for everyone to be assured of getting those treatments if in need of them. The Ex Ante Pareto Principle gives a sufficient condition for an assurance of treatment not to be worth its cost.

Applying the principle requires both extensive knowledge and careful reflection. One must be broadly knowledgeable of what life can be like under various conditions, and one must engage in carefully thoughtful experiments about the risks worth taking in life. Are such thoughtful experiments practicable? They are surely impossible to perform with any precision, but I think they can be of value. In the first place, I maintain, such thoughtful experiments can reassure us on matters that seem obvious in health care policy, but that we might begin to doubt when we realize how insecurely based is much of received wisdom regarding health care. We can reassure ourselves that when effective treatments of debilitating or life-threatening ailments are known, the assurance that those treatments will be available, if needed, may be of great value. The shock of current medical costs may hide that from us. The proportion of the gross national product devoted to health care has approximately doubled in recent decades, reaching nearly 10 percent. These facts in themselves, though, do not show that anything has gone wrong, and the Ex Ante Pareto Principle can help us see why not. As medical treatment becomes more effective, and as expensive, effective treatments are discovered for serious conditions that were previously untreatable, it may become rational, from a prudential point of view, to pay more for assurances of medical treatment. That can easily be seen in an extreme case. If, at one time, there are no known effective treatments, it is then irrational to pay anything for the assurance of treatment. If, later, effective treatments are discovered, then it is clearly rational to pay something, at least, for the assurance of receiving them if one needs them. There is no reason why further advances in medical knowledge should not further increase what it is rational to pay for to ensure access to treatments one may need. The Ex Ante Pareto Principle extends this conclusion to the society at large.

On the other hand, if the Ex Ante Pareto Principle is valid, then there is no defense for a universal precept: "Where life is at stake, cost is no object." That precept may apply in specific circumstances, where the cost of the best treatment is moderate and the treatment is effective in saving life and restoring health. What counts for these purposes as moderate cost may indeed seem horrendously high. It

may be, for all I have said, that there are now no serious ailments for which effective treatments are known, where the most effective known treatment is not worth the cost.⁵ The Ex Ante Pareto Principle and considerations of rational prudence, however, tell us that the best known treatment for a serious ailment might not be worth the cost, ethically speaking; I leave it open whether, at present, there is, in fact, any serious ailment, the best known treatment for which is not worth the cost.

Applications: Equal Access

In some circumstances, then, equitable access to health care will not be unlimited access, or even access to the most effective treatment, by everyone with a serious treatable ailment. What, then, does equity demand? An answer that needs to be considered is that equitable access is fully equal access. What might "fully equal access" mean? Clearly, equity does not demand equality in the sense that everyone shall receive the same medical care, regardless of what ails him. The claim that equitable access is equal access is rather that the health care available to a person should depend on his medical condition alone. It should not, the claim is, depend on such factors as his income or where he lives. If we are to consider a treatment to be worth the cost for one person, then equity demands that we consider it to be worth the cost for anyone else whose medical condition is precisely the same.

If, however, the Ex Ante Pareto Principle is valid, then equity cannot demand fully equal access to health care in all possible circumstances. The Ex Ante Pareto Principle suggests that we can consider questions of social ethics in part as questions of rational prudence in the selection of costly insurance packages. From the standpoint of rational prudence, there is a tradeoff between health insurance and other good things in life. If an individual must forego other good things in life in order to ensure that he can obtain certain kinds of expensive health care should he need them, it may be rational for him to prefer not to do so. A health insurance package has a social cost; if it is to be honored, resources must be expended on health care that could be put to other uses. One test of an economic system, and the access to health care that it provides, is to ask whether the prospects of anyone could be improved at no cost to the prospects

⁵ In speaking of "the most effective known treatment," I do not mean to imply that treatments divide neatly into the "known" and the "unknown." The likely effectiveness of a treatment is often a matter of controversy, and that complicates what should be said here.

of anyone else. Could the prospect he faces in life be made more desirable by giving him a more extensive package of health insurance at his own cost? (The phrase "at his own cost" here means devoting fewer resources, apart from health care, to enhancing the prospective intrinsic reward of his life in such a way that the prospects of others are left undiminished.) Alternatively, could his prospects be improved by reducing his health insurance and letting him recoup the difference in social cost? In either case, an alternative level of health insurance will be prospectively Pareto-superior, and hence better from an ethical standpoint. Thus with the prospects of everyone else held fixed, there will be a package of health insurance and other economic entitlements that is optimal from his prudential standpoint. If his package of economic entitlements is not prudentially optimal, then it is prospectively Pareto-superior for him to have his optimal package, with everyone else's prospects left unchanged.

Equity demands full equality of access to health care only if, under equitable economic arrangements, the same insurance package is prudentially optimal for everyone. That is unlikely to be the case, at least if what is prudentially optimal is determined by tradeoffs at the margin. In the first place, the same package of incremental health care benefits may cost more for one person than for another. It may cost more, for instance, to assure treatment of a given quality in a sparsely populated area than in a thickly populated area—more, as I shall say, in the country than in the city. That will be because of economies of scale and transportation costs; if specialists and specialized equipment are dispersed in the country, they may be underemployed, whereas if patients from the country are brought to specialists in the city, their transportation will have its costs, both in patient time and in resources diverted to providing the transportation. It may be prudentially optimal, then, for those in the country to accept a less desirable package of health care benefits in return for a more desirable package of other economic entitlements.

Consider next income differences. Perhaps under equitable economic arrangements, incomes would differ only with need—but suppose they do not. With a low income, the marginal dollar is devoted to pressing needs; with a higher income, to less urgent needs. The marginal utility of income declines. If a package of incremental health benefits enhances the prospects of rich and poor to an equal degree, it may be worth its cost for the rich, but not for the poor. It is hard to see why the prudentially optimal package of health benefits should be the same for all, under equitable economic arrangements, unless equity demands that income be distributed strictly according to need in general.

Arguments of the kind I have given are often used to show that there need be no public policy specifically intended to ensure equity

in access to health care. Rather, it is maintained, public policy should ensure equity in the distribution of income, and then the market should decide what package of health benefits each person shall receive. I do not regard such a conclusion as plausible, and it is certainly not a consequence of the Ex Ante Pareto Principle. The market will decide efficiently only if it responds competitively, if there are a wide variety of insurance packages available, and each person chooses prudently what package to buy. Inevitably, the market for health care departs grossly from conditions of perfect competition, and the desirability of alternative insurance packages, covering small risks of profound calamities, is not something we can expect each person to work out for himself with great prudence. Perhaps, even so, we should accept the choices people make so long as they are normally competent adults—but the choice among insurance packages would have to be made well before the age of reason, and perhaps before conception, for insurability itself to be equitably distributed. Insurance of life prospects is not something on which a person can make his own choices, for by the age of competence it may be too late.

Nothing I have said refutes the claim that, in our current circumstances, a rough equality of access to health care is a demand of equity. In the first place, it may turn out that, although no system of equal access is Ex Ante Pareto-efficient, the most equitable of economically feasible social arrangements would include equal access to health care. There may be no way, through general economic policy and economic arrangements, to adjust each person's access to health care to his prudential optimum—or no way that does not violate other demands of equity. In the second place, it might be that few medical decisions are marginal; most treatments are either clearly worth their cost for everyone or worth their cost for no one—where whether something is worth its cost is reckoned from the prospective, prudential standpoint of whether it would be rational for a person to buy insurance to cover it. The question of whether equity of access means full equality of access for such special reasons will be touched upon in the next section.

Applications: A Decent Minimum

If the Ex Ante Pareto Principle is valid, then equity of access to health care may not mean access to the best health care feasible, and it may not mean fully equal access to health care. So I have argued in the last two sections. Another widely held precept is that what equity requires is a "decent minimum." Everyone, it is suggested, is morally entitled at least to certain kinds of health care, and he may reasonably demand of his fellows that society be organized to

assure him of those kinds of care if he needs them. Health care of other kinds he may buy or provide for with insurance, but there is no general moral entitlement for health care that goes beyond this decent minimum.

How might it be argued that everyone is entitled to such a decent minimum of health care? Moreover, if that can be argued, by what criterion may we distinguish between care that is included in the decent minimum and care that is not? I think that plausible answers may be given, but they must be grounded on an ethical precept that supplements the Ex Ante Pareto Principle. One precept that will do the job is the claim that everyone is entitled to a decent minimum of economic welfare in general. Suppose we are granted that, and suppose we have established what that decent economic minimum is. Then from economic considerations and considerations of rational prudence, it can be argued that there are certain kinds of health care that should be available to everyone who needs them.

The kinds of health care that comprise this decent minimum are those that it would be prudent for anyone, even at the decent economic minimum, to ensure for himself, if he himself had to bear the inclusive social cost of the assurance. The inclusive social cost here is a matter both of the resources prospectively needed to fulfill the assurances, and whatever losses in economic efficiency result from the system that is set in place to fulfill the assurances. It may be that resources can be transferred to assuring certain kinds of health care for those at the decent economic minimum only in a leaky bucket—i.e., only with some inefficiency—because of, say, the “moral hazard” in any insurance scheme (Varian, 1978: 239–241). Those losses in efficiency are counted in the “inclusive social cost” of a package of assurances. To say that in economic state P , it would be prudent of a person who lacks certain assurances of access to health care to secure them, even if he had to pay the inclusive social cost, is to say that there is an alternative economic state in which he has those assurances, in which his prospects are more desirable than in state P , and in which no one else's prospects are less desirable than in state P .

A decent minimum of health care, then, consists of those kinds of health care which it would be prudent for anyone, even at the decent economic minimum, to insure himself for, if he could buy any package of health insurance he chose at its inclusive social cost. Call this *essential* health care. We have been assuming that in the best economically feasible state, everyone is assured at least a decent economic minimum of a certain level. It follows from this, as well as from the definition of essential health care in terms of this decent economic minimum and the Ex Ante Pareto Principle, that in the best economically feasible state, everyone is assured of essential health care. For suppose otherwise, and consider a person who is not assured

essential health care. From the definitions of essential health care and inclusive social cost, it follows that there is an economically feasible alternative state, in which he is assured essential health care, which state is Pareto-superior *ex ante*. By the Ex Ante Pareto Principle, this state is better. We have seen, then, that in the best economically feasible state, everyone is assured essential health care, for otherwise there would be an economically feasible state that was better.

Essential health care is the health care it would be prudent for anyone assured a decent economic minimum of income to ensure for himself, if he could buy any conceivable health insurance package he chose at its inclusive social cost. Can this abstract formula be filled out? Filling it out would require ascertaining the level of the decent economic minimum. So far, we have only assumed that there is a moral entitlement to some decent economic minimum or other, but said nothing about how high this minimum is. To say anything further, we would have to proceed either from intuitions about what constitutes a decent economic minimum or from an ethical theory that stands behind the claims of universal entitlement to a decent economic minimum. With either procedure, considerations about the urgency of access to health care in ensuring desirable prospects in life would presumably play a role.

From the intuitive standpoint, I think we can say this. We know from our own lives that it is highly important to the desirability of a person's prospects in life that he have extensive assurances of access to health care he may need. Thus, if the decent economic minimum is anything like what it is commonly supposed to be in our society, it will be prudent for a person at the decent economic minimum to buy an extensive package of health insurance at its inclusive social cost. A decent minimum of access to health care will be extensive.

The most widely held systematic moral theory, utilitarianism, seems to yield the same rough conclusion, with the advantage that the conclusion could be made more precise given more information on the costs and prospective benefits of various kinds of health care. Most utilitarians have claimed that the marginal utility of income (the increase in the intrinsic reward of a life that an extra dollar of income facilitates) declines as income increases. Thus, with a fixed income to divide, greatest total intrinsic reward tends to come from roughly equal distribution. Inegalitarian economic incentives, however, can increase the total income to be distributed and so the best economic policy is a compromise between egalitarianism and a free market. The reason for the declining marginal utility of income is that a marginal dollar at a low income goes to meet urgent needs, whereas, at a higher income, the most urgent needs have been met and the marginal dollar goes to meet less urgent needs. It would seem that certain needs—in particular, the needs for food and drink, for shelter, and for health

care when sick—are so urgent, that if a system of economic incentives can ensure the satisfaction of these needs, then the cost in foregoing other expensive sources of intrinsic reward in life in order to ensure the fulfillment of these needs might be very great, before it becomes worthwhile to forego the satisfaction of these urgent needs in return for greater satisfaction of less urgent desires. This claim needs to be qualified in the case of medical care. The medical care that has promise of immensely contributing to intrinsic reward in life is care that is reasonably likely to make a difference between a long life well worth living, and early death or a life ill worth living. In a reasonably prosperous society, a utilitarian decent minimum will include such care, even if the cost is high. If all effective treatment were of this kind, then barring expense that was truly extraordinary, the decent minimum would include all treatment that was advisable on purely medical grounds.

The difficult cases, apart from treatments that are truly stupendous in their cost, will be treatments that hold out some hope of extending and ameliorating lives worth living, but where the hope is miniscule or the life is but little worth living. These include heroic measures to extend the lives of people incurably infirm, and marginal tests where the possibilities of detecting a serious, treatable condition are remote. Here, the Ex Ante Pareto Principle suggests, we should apply a prudential test: Would one's prospects in life be better if one had assurances that such treatment would be provided, or if, alternatively, one could spend the inclusive social cost of providing those assurances on something else? At the decent economic minimum in a society like ours, the answer may sometimes be that the resources in question should be devoted to enhancing the lives of the healthy.

Assessing the Principle: Doubts and Further Reflections

In the preceding three sections, I have simply assumed the Ex Ante Pareto Principle, and applied it in a rather straightforward manner to the economic considerations involved in access to health care. There are grounds, though, for questioning the principle—or at least for questioning the rather direct way in which I have been applying it.

A first ground for doubt is simply that some of these straightforward applications of the Ex Ante Pareto Principle seem to go against our moral intuitions. In particular, it seems immoral to “put a price on life” and withhold life-saving treatment when the cost is too great. To risk life is one thing, to give up saving a life is another; and our moral views about the two seem quite disparate. It is, after all, but a short step from the Ex Ante Pareto Principle to a kind of utilitar-

ianism, and arguments that utilitarianism is in conflict with common moral opinion are widely put forth as a decisive objection to utilitarianism. The slide from the Ex Ante Pareto Principle to utilitarianism goes as follows. The Ex Ante Pareto Principle deals in prospects. From what point, we may ask, are those prospects to be figured? There seems to be no reason to choose any time after conception; perhaps, then, we should take the time of conception itself. Or perhaps we should consider prospects as of an even earlier time, of a hypothetical time before anyone had any of his personal characteristics, or any position in the world. Now, at that hypothetical time, the prospects of everyone, given a set of economic arrangements, will be the same. Thus, the Pareto Principle Ex Ante Everything gives a complete ordering of institutional arrangements that a society might have, by the desirability in prospect of being anybody in the society subject to those arrangements. To order alternative social arrangements in that way is simply to order them by average desirability of prospects—by average expected utility—and that is a form of utilitarianism.

Does that discredit the Ex Ante Pareto Principle? Perhaps, instead, it establishes a form of utilitarianism as ethically valid. That has indeed been argued (Harsanyi, 1953; 1955). Perhaps our antiutilitarian ethical intuitions are simply extensions of our widespread prudential irrationality in the face of risk. Proverbially, we want to lock the barn door after the horse has been stolen. We tend, psychological experiments show, to be unwilling to choose losses that are certain, but small, even to avoid a substantial risk of great losses. The same gamble may be accepted or rejected, accordingly as the payoffs are labeled as gains or losses; we will gamble with losses and play safe with gains (Kahneman and Tversky, 1979). A military unit may well prefer an attack in which a number of people can be expected to die, to a suicide mission by a single person selected by lot. If we cannot, in the end, conclude that these prudential tendencies are rational, that throws into doubt the tendencies in our ethical thinking that mirror them.

Moral intuition alone, then, is weak ground for rejecting the Ex Ante Pareto Principle, or even full utilitarianism. The utilitarian can explain the intuition as an effect of prudential tendencies that are manifestly irrational. If intuitions are to bear much weight, they must be accompanied by diagnoses of how the kinds of considerations that support the Ex Ante Pareto Principle might lead us astray in our moral thinking. If our social ethic is to be for man and not man for ethics, if our social ethic is to be more than a set of arbitrary taboos to which we feel attachment, then the human benefit in a morality that departs from the Ex Ante Pareto Principle must be explained.

Here, appeal might be made to a number of considerations. In the

first place, there is a strong advantage, from the standpoint of human benefit, in a morality of simple precepts. Such a morality, if accepted, may well be more robust and influential than a morality of refined criteria, subtle in their application. For this reason, many philosophers who accept a roughly utilitarian rationale for ethics are drawn to "rule" utilitarianism, evaluating rules by the benefits their acceptance would bring, but judging an individual action, not by the benefits it produces, but by whether it conforms to the rules, acceptance of which would bring the greatest benefit (Brandt, 1979: chap. 15). The most beneficial rules may be simple rules that can grip us strongly. For example, doctors, nurses, technicians, and administrators who are devoted to the precept that life must be preserved, whatever the cost, may give better care, even by utilitarian standards, than they would if they tried to guide their actions by a cold economic calculus. The economic calculus may not well inspire the degree of heroism and devotion that it certifies as optimal. Simple, powerful ideals may thus evoke action more conducive to the general happiness than would a direct, calculating concern with the general happiness. Precepts that violate the Ex Ante Pareto Principle may be justifiable on such rule-utilitarian grounds.

In the second place, the power of an accepted social ethic for good—its power to enhance the lives people lead—depends in part on its setting standards by which people can hold each other responsible. Direct applications of the Pareto Principle lack this virtue, for the economic facts involved in any reasonable application of the principle are too complex for it to be evident when a person is faithfully applying the principle. These considerations yield a possible interpretation of the widespread apprehension that to apply such a principle directly to matters of life and death would be to play God; to apply the principle directly would be to make judgments on matters of vast importance, without there being clear, easily applicable standards by which one can be held accountable for those judgments. Sometimes, to be sure, a person is placed in such a situation inevitably—in matters, for instance, of war and peace in a dangerous world. There are strong reasons, though, for preventing anyone from having such power when it is possible to do so.

In the third place, the considerations to which I have been appealing in direct applications of the Ex Ante Pareto Principle have been quite narrow. I have been considering what a package of health insurance will do for the prospects of the person insured. I have not considered what offering health care, or withholding it, does to the quality of the interpersonal relations of those who provide or withhold it.

Feelings can justify actions, even when those feelings are irrationally based (Brandt, 1979: chap. 6). It may be irrational to lock the barn door after the horse has been stolen, but we feel better doing it, and

the feeling itself, however irrational its basis, may justify the action. Now, the knowledge that we shall care for each other in calamity, even if the cost be great, may strengthen our feelings of social fellowship. Perhaps it is in these feelings toward each other, and not only in direct benefits to our health, that we should expect to find ethical justification in matters of health policy. This point about feelings applies to the widespread fear of allowing anyone to play God; not only may such power be dangerous, but it arouses deep fears. It would seem that, risks being equal, people fear deliberate harm from others much more than accidental harm. This may be irrational, but given the psychological fact (if it be a fact), an ethic that allows us to risk lives and treat the victims may bring us more intrinsic reward in life than a policy that results in fewer lost lives.

The gains and losses of providing and withholding treatment, then, apply not only to the person whose treatment is in question, but to the rest of us as well, in the ways we experience our lives in our society, and our emotional ties to our fellows. Narrow economic loss—loss, that is, reckoned only in terms of effects on the life of the person whose treatment is in question—may be made up for in emotional gain. Not that this must invariably be so; whether it is, in any particular case, will depend in part on the economic cost. If an illusion that we regard life as priceless strengthens the bonds of social fellowship, then whether we should indulge that illusion may depend on how much it costs to do so. With the development of new, effective, extraordinarily expensive treatments, we may be increasing the economic cost of maintaining that illusion, and the cost of the illusion may begin to outweigh its benefits.

Does that mean that we must choose between two incompatible classes of goods, narrowly economic goods on the one hand, and the goods of mutual respect on the other? Must the economic cost of mutual respect keep increasing, as we develop increasingly expensive ways of expressing mutual respect, through heroic, life-preserving measures? I do not see why that should be so. We ought rather to remind ourselves that concern for each other, and respect for humanity in each other, does not require a willingness to sacrifice more for each other than it would be rational for one of us to sacrifice for himself in prospect. If it is not worth the cost to anyone to ensure a kind of expensive treatment in a calamity, then we should not feel that we owe each other efforts that it is irrational for anyone to secure for himself. As the economic cost of older conceptions of humanity becomes higher, we need to shift our attachment to conceptions of humanity that are not so costly—just as when, over the past few centuries, a more demanding conception of what we owe each other has become possible to realize at a cost that is not inordinate, we have accepted conceptions of man's humanity to man that are, in

certain respects, more demanding than those of our grandparents. Crudely put, what I am suggesting is this: that whereas cheap violations of narrow economic rationality may well be worth in sentiment what they cost, as violations become costly, we should refine the sentiments involved. To do so is a natural, if painful, result of economic change, and it can often be desirable. One set of changes in our moral sentiments that may be called for by current technology is a refinement of our ways of thinking about risk, and about what we owe each other in the way of extraordinarily expensive treatments.

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Unequal Need: A Problem of Equity in Access to Health Care

H

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An Overview

Fair access to health care is an uncontroversial objective of social policy. Controversy arises when this objective is given operational significance through an interpretation of "fair." Our concern will be to examine fair access in relation to differentiated need for health care services. We shall argue that distinctive problems of equity arise because health care needs are markedly unequal, and that these problems should be clearly distinguished from other equity issues—those arising from unequal access to generalized resources that may be directed to meet any need or afford any form of satisfaction. Our discussion will draw away from these inequalities, which are not the direct concern of health care policy, so that we may focus on questions of equity inherent in meeting health care needs.

We shall begin by characterizing health and relating it first to other primary goods, and then to a conception of the individual person. In this discussion we shall suggest some of the distinctive features of health as a good that must be accommodated by an account of equity in access to health care. We shall then distinguish two very different states of affairs in which the provision of health care by straightforward market devices may be expected to lead to similar inequalities in the actual levels of health enjoyed—situations in which persons with equal resources face health care needs that differ in magnitude, and situations in which persons with unequal resources face health care needs similar in magnitude. We shall consider the application of simple ethical decision rules to these two situations,

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showing the different implications of ethical theories based on maximizing social welfare (utilitarianism), assuring positive rights (Kantian constructivism), and protecting negative rights (libertarianism).

None of these theories is, in our view, fully adequate to guide us in resolving questions of equity in access to health care. None accommodates the particular features that health as a good exhibits. But we shall not conclude on a critical note. Rather, we shall endeavor to make constructive use of the theories discussed in formulating a more acceptable evaluation of inequalities in the provision of health care. This account will permit us to focus on those distinctive equity considerations related to differences in health care needs, without confusing these considerations with other equity issues. These other issues may indeed have implications for access to health care, but they demand attention in other areas of social policy.

The Concept of Health

Health as a Natural Primary Good. A reasonably clear conception of health is offered by Norman Daniels: “[h]ealth is the absence of disease and diseases . . . are deviations from the natural functional organization of a typical member of a species.”¹ Space does not permit a full defense of this conception here, but we note with Daniels that in accepting it, we specifically reject an alternative conception of health as “a state of complete physical, mental, and social well-being.” This definition, adopted by the World Health Organization,² “over-medicalizes” social philosophy and social policy, reducing all social goods to health. We concur with Daniels in considering health a more specific good. This position is, we believe, accepted in common usage, and demarcates a factually and ethically significant boundary between goods. Access to health care, understood as access to care aimed at preventing or reducing deviations in natural functional organization, is then the focus of our enquiry.

We consider health to be a *primary good*. The conception of a primary good is taken from John Rawls, who characterizes primary goods as those “things that every rational man is presumed to want. These goods normally have a use whatever a person’s rational plan of life.”³ Underlying this account is the view that “[T]he good is the satisfaction of rational desire.”⁴ The primary goods therefore enter into every normal way of satisfying such desire. Rawls’s individualistic and pluralistic charac-

¹ Norman Daniels, *Health-Care Needs and Distributive Justice*, PHILOSOPHY AND PUBLIC AFFAIRS, Vol. 10, No. 2, pp. 146-179.

² *Ibid.*

³ John Rawls, *A THEORY OF JUSTICE*, Harvard, 1971, p. 62.

⁴ *Ibid.*, p. 93.

terization of the good is, we believe, consonant with the basic value consensus implicit in liberal democratic society.

The claim that health is a primary good, entering into every rational plan of life, is hardly controversial. We may therefore turn directly to the particular features that health exhibits. Rawls offers a basic division of primary goods into *natural* and *social*: “[R]ights and liberties, powers and opportunities, income and wealth” constitute the principal social primary goods; “health and vigor, intelligence and imagination” are natural goods.⁵ Underlying this distinction is the fact that the distribution of goods in the first group is essentially influenced, if not fully determined, by the particular features of a social system, and so may be brought under deliberate social control; however, distribution of goods in the second group is relatively immune to social control, at least of a planned kind. Some goods in the first group may indeed be thought of as fundamental features of a social system—rights and liberties, for example. Goods in the second group, however, such as intelligence and imagination, constitute the actualization of natural capacities.

Health is in obvious and important respects a naturally based good. Many, although of course not all, of the deviations from natural human functioning that constitute disease are occasioned by factors—whether hereditary or environmental—that are not subject to deliberate social control. It is true and important that we are increasingly aware of those deviations that are occasioned by social factors, and over which social control may be deliberately exercised. Many diseases are occupationally based. The incidence of ill effects due to exposure to radioactive materials reflects the social use of such materials. The incidence of lung cancer reflects the extent of the habit of smoking. An important group of deviations from normal functioning results from measures intended to eliminate other deviations. Allergic responses to penicillin and defects in prenatal development resulting from the mother's use of thalidomide are two examples.

Access to care for diseases that are socially occasioned in ways subject to control raise problems importantly different from those on which we shall focus here. We should argue that care for such diseases should be considered part of the cost of the activities occasioning them. Some of these activities, such as smoking, may be viewed as entirely discretionary; care for ill effects may then appropriately be the individual's expense. But others are not discretionary. One may argue that care for occupation-related diseases should be legally required to be assumed by the employer, over and above standard wages and benefits; if this precludes profitable employment, then we should conclude that the total social costs of the activity exceed

⁵ *Ibid.*, p. 62.

the total social benefits. Care for diseases resulting from public activity should be a public charge; if individuals are left to pay the costs for treatment, then they are being singled out to bear the expense of social activity in a manner unrelated to the benefits they may expect from such activity. This is clearly inequitable and discriminatory. But we shall not pursue these matters here; our concern is not with determining standards of equity in access to health care where the need for such care may be attributed to some specific public or private activity, but rather where the need is not socially occasioned.

Social Control of Health. Although health is in significant respects a natural primary good, it differs from other natural goods—and in particular from talents, aptitudes, and desirable traits of character (or virtues)—in the degree to which the enjoyment of the good by an individual is susceptible to deliberate alteration by social measures. Lack of health is, by and large, more readily remediable than lack of intelligence. And where it is not remediable, lack of health is often more readily compensatable than lack of other natural goods. Extending beyond but related to these differences, health may be distinguished from the typical natural primary goods by the way in which it enters into our conception of a good human life, and into our conception of an individual person.

It is essential to develop and clarify these points. Intelligence, imagination, and more generally talents, aptitudes, and virtues, are relatively unalterable, as potentialities, by deliberate intervention. Circumstances do of course affect the degree to which such characteristics are fully realized in a person's behavior. The actualization of an individual's musical potential is largely a socially determined phenomenon, but we suppose that the potential itself is relatively unalterable; no circumstances would enable me to be a concert pianist, or a tone-deaf man a competent musical critic. In the fairly recent past a person's state of health was also relatively unalterable by deliberate intervention. But the rapid advance in medical technology during the past century has significantly altered our capacity to treat states of health and disease. Increasingly we remedy or compensate for deviations from natural human functioning. We provide wheelchairs for those lacking locomotive capacity, and access ramps for wheelchairs. We make eyeglasses and hearing aids; we communicate in Braille or in signs; we offer special training and assistance to cope with normal human environments even in the complete absence of one of the basic senses. We repair malfunctioning organs or provide artificial substitutes. There are of course limits to our abilities to repair and substitute, but these limits are being steadily relaxed. The natural extent to which a person enjoys or would enjoy the good of health is thus only a starting point.

Our ability to alter a person's state of health or level of functioning has significantly affected our conception of the place of health in an individual's good life. Here again we may contrast health with other natural goods. As part of our pluralistic view of values, we suppose it possible for persons with different talents and virtues to live good lives, and the good lives they live will reflect their particular characteristics. However, we do suppose that those who are more gifted, who are endowed with a greater supply of certain natural goods, are able to enjoy a richness of experience not accessible to those lacking such gifts. In certain respects the lives of the better endowed possess, we may say, a finer texture.⁶ It is not possible to compensate persons for this lack of texture, nor for the related lack of certain talents and virtues. The good life for the unimaginative does not compensate them for their lack of imagination.

At one time our conception of the good life for an individual was also related to the extent to which he or she naturally enjoyed the functioning typical of the human species. But increasingly we reject this idea. Of course we do not and can not do so altogether; the blind person can neither enjoy nor be compensated for not enjoying the pleasures of sight. But so far as possible—and the advance of technology makes it increasingly possible—we consider the good life for a person who is handicapped or impaired to be not one conditioned by that handicap or impairment, but rather the life the person could live given normal functioning. This is made possible by remedial or compensatory measures. We endeavor to integrate the widest possible range of persons into normal human society, rather than providing specially sheltered or restricted environments for them.

Health is thus distinguished from other natural primary goods not only because it is more amenable to deliberate social intervention, but also because the good life for an individual is related to his or her possession of other natural goods but not to his or her particular condition of health. We suppose that the good life for any individual involves the exercise of his or her talents and aptitudes, the cultivation of his or her virtues, and the fulfillment of his or her interests, given normal human functioning; and so far as possible, we seek to make such a life available.

A person's health care needs may be determined by considering on the one hand natural human functional organization, and on the other hand the existence of socially feasible procedures to remedy or to compensate for deviations from such organization. A person needs, from the standpoint of health care, whatever is both necessary and feasible to enable him or

⁶ J.S. Mill's discussion of the qualitative dimension of pleasure in Chapter 2 of *UTILITARIANISM* is relevant to the ideas developed here.

her to approach natural human functioning as closely as possible. But these needs are also needs for a good life, since the good life is characterized by the fulfillment of a rational life plan based on individual characteristics and given normal functioning. The moral significance of health care needs is then to be found, not in the mere idea of need—since in our view need is always understood as relative to some objective, and an objective need not in itself possess moral standing—but rather in the idea of natural and normal human functioning, which is a core part of our conception of a good human life.

Health and the Individual. A conception of the individual lies behind the view of health and health care needs that we have just sketched. To develop this conception fully would require a study much more extensive than our present enquiry, but we should point out that essential to it is a distinction between the status of an individual's condition of health and his or her abilities, interests, and traits of character. The latter we take to be constitutive of a particular individual. We expect these characteristics to develop over time, and we recognize certain limited nondevelopmental alterations in them; yet we speak only partially metaphorically when we say of someone who undergoes marked alterations in character (falling outside a normal developmental pattern) that he or she is a different person. Such natural goods as intelligence, imagination, and industry, as constitutive features of a person's character, thus enter directly into individuality, making him or her that particular person, that particular individual.

But a person's condition of health is not similarly constitutive of individuality. A person who is handicapped or impaired is thought of as something less than his or her real self—less than the self who would emerge were the handicap or impairment overcome. Disease, understood as deviation from natural species functioning, is something that befalls a person, an accident in relation to nature or identity. We do of course recognize that there is a connection between conditions of health and character traits, interests, and aptitudes, so that the line we are drawing does not constitute an impassable barrier. Indeed, we may suggest that the way in which we distinguish what is essential to a particular person from what accidentally befalls that person is affected by our beliefs about what is changeable through deliberate intervention, and so reflects a particular stage in the development of human technology. We might reflect here on the examples of lepers, epileptics, and consumptives. Our conception of these people has changed as the supposition that leprosy, epilepsy, and consumption are permanent, constitutive conditions has given way to the realization that they are temporary, accidental diseases.

Broadly speaking, then, a condition of health or disease, unlike a degree of intelligence or imagination, is accidental to a

person. And so health falls between the natural and social primary goods. Although naturally based, a person's state of health, like a state of wealth, is largely socially conditioned and is alterable by deliberate, planned social intervention. Also, and again like a state of wealth, health is not constitutive of the person's individual identity. We shall see that this peculiar status of health as a primary good raises distinctive ethical questions concerning equity in access to health care services.

Health and the Good Life. Before developing this claim, let us conclude our discussion of health as a primary good by locating questions about the distribution of health care in the general framework of an evaluation of social practices and institutions. We shall assume that, from an evaluative standpoint, society is to be treated as instrumental, "that government is only a convenience created and managed by the people, with no powers of its own except those voluntarily granted to it by the people."⁷ As a convenience, government and other social institutions may be judged by their contributions to the good lives of the individual members of society who are the source of their institutional powers. Although this assumption is not beyond controversy, it is grounded in the consensus of liberal democratic peoples, and it may be taken as common ground among the different ethical principles and theories we shall introduce.

From the standpoint of social evaluation, such primary goods as talents, aptitudes, and virtues are givens. Society has no role in distributing these goods, but rather is concerned with their effective actualization, so that each person may enjoy to the fullest possible extent the good life related to his or her particular share of these natural goods. Society recognizes as good the fulfillment of rational desire. Thus, although possession of a larger share of the natural primary goods may make possible a richer and more finely textured human life, this does not mean that such a life should be socially more favored. Rather, society makes it possible for persons with different characteristics, and so with different endowments of natural goods, to lead their own lives. In taking the distribution of natural goods as a given, and in promoting the good life of each person whatever that person's endowment of these goods may be, society satisfies the requirement, happily formulated in a phrase of John Rawls, that it be "a cooperative venture for mutual advantage."⁸

The social primary goods are then instrumental to this task. The rights and liberties, powers and opportunities, income and wealth established by social practices and institutions are not

⁷ Ronald Reagan, *What July Fourth Means to Me*, PARADE, June 20, 1981, p. 5.

⁸ Rawls, *op. cit.*, p. 4.

to be considered as defining the good lives of the members of society; rather, they are the means whereby those members, whose good is defined in relation to their abilities and interests, are to realize that good through mutually beneficial interaction. Thus, from the standpoint of social evaluation, the distribution of social primary goods is the fundamental object of appraisal. In the best society the social primary goods must be distributed in a way that the good lives of the members of the society are optimally furthered. The various ethical principles that we shall introduce are attempts to specify this optimal furthering of the good lives of the members of society. To this point our account is intended to be neutral about the choice among those ethical views—utilitarianism, Kantian constructivism, libertarianism—that we mentioned at the outset.

Now we may suppose that health, although in important respects a natural good, is to be classed primarily with the social primary goods as an object of evaluation, so that the distribution of health care among the members of society should optimally further their good lives. The good society will enhance the health of its members to the greatest possible extent, subject of course to budgetary constraints requiring it to make choices between health and other primary goods. Although this statement may appear uncontroversial, we shall show that it occasions very real ethical problems. The natural basis of health affects the extent to which we may interpret its enhancement as part of a “cooperative venture for mutual advantage.” To examine more specifically the questions of equity raised by health, and in particular by differing health care needs, we now turn to consider inequalities in levels of health resulting, first, from differing needs, and second, from differing resources.

Health in Model Societies

Unequal Needs, Unequal Resources. We introduce two simple model societies. We shall label the first society (*N*), since health care *needs* differ among its members, although the resources available to each person to meet his or her various needs and desires are fully equalized. We shall label the second society (*R*), since *resources* differ among its individuals, although all have the same health care needs. For the purposes of our illustration we ignore the real-world complications that would arise in establishing, or even in fully specifying, either form of equality. We assume for simplicity that in each society all goods are initially supplied in a market free from both positive and negative externalities. We treat the members of our societies as independent adults, thus eliminating any distinction between individual and household. We also suppose that these adults are very similar in their preferences and interests, and in their needs apart from health care.

In society (N) we should expect rational individuals to differ in their allocations of resources among health care and other goods; despite the fact that all have equal resources, members have different health care needs. The greater the need, the larger the share of resources we should expect to be allocated to health care. At the same time, the greater the need, the greater the final degree of deviation from natural functioning we should expect to be accepted. If expenditures on health care were increased, the actual level of health enjoyed would decrease. The reason for this is evident. If two individuals with equal resources differ in health care needs, then the one with greater need cannot enjoy as high a level of overall well-being as his or her more fortunate fellow. In the normal case an optimal allocation of resources will yield reduced well-being to the person with greater need, not exclusively in the area of health, nor exclusively in other areas, but rather in each of the different goods he or she seeks. Faced with being required to give up some amount of other goods to maintain a level of health equivalent to his or her fellow, or to give up some degree of health to maintain equal consumption of other goods, the rational individual with greater health care needs (subject to the usual rules of diminishing marginal utility) compromises and accepts a lower consumption level of both health and other goods.

In society (R) we should expect rational individuals to spend more on health care the greater their overall resources, despite the fact that all have equal health care needs. Those with lesser resources must then expect a lower actual level of health than their more affluent fellows. There is a clear parallel between the effect of increased health care need on consumption in society (N) and the effect of diminished resources on consumption in society (R). For if two individuals with equal health care needs have different resources, then the one with lesser resources cannot, other things being the same, enjoy as high a level of overall well-being as his or her more fortunate fellow. Faced with the choice of giving up some amount of other goods to maintain a level of health equivalent to his or her fellow, or giving up some degree of health to maintain equal consumption of other goods, the rational individual with lesser resources compromises and accepts a lower level of consumption of both.

Thus our two model societies may well exhibit similar distribution patterns of well-being among their individual members. Persons in (N) with few health care needs may enjoy a mix of health and other goods comparable to persons in (R) with extensive resources; persons in (N) with substantial health care needs may have to accept a mix of health and other goods comparable to those in (R) with few resources. But this identity of outcomes need not lead us to conclude that the same ethical issues arise in the two societies. Indeed, we shall argue that what may well be ethically unobjectionable differences in

health conditions among persons in (R) correspond to ethically unacceptable differences in (N).

Equalizing Health Care. But before turning to an evaluation of the inequalities in health and health care in the two societies, we should first consider how equalization might be effected. Suppose that the members of (N), concerned to make the good of health equally available to all, despite differences in health care needs, agree to replace the market provision of health care by a system of universal insurance. Under such a system each member would pay the same premium and receive health services that, within limits of feasibility, would equalize the levels of health actually enjoyed by the members of society (N). The sole rationale for this insurance, we must note, would be to bring about such equality. In our own society the rationale generally offered for health care insurance is based on uncertainty about need, but in the simple world of society (N) we ignore all such uncertainty, supposing persons to be fully aware of their health care needs, both now and in time to come. In such circumstances insurance serves no economic purpose.

Since individual resources are equal in society (N), the appropriate level at which to set the universal health care premium is readily calculable. In effect all individuals face the same trade-off between health and other goods, so we may consider the calculation of any member of society selected at random. In the original market, different degrees of need correspond to different cost-benefit relations for the purchase of health care services. Each degree of need, and so each cost-benefit relationship, determines a unique optimal allocation of resources among health care and other commodities. Now the requirement that a fixed premium afford the same level of health for all determines a particular cost-benefit relation between the good of health and the resources required to secure it, and so a unique optimal market allocation of fixed resources among health and other commodities. This allocation determines the appropriate premium for any individual.

It will be evident that the premium so established ensures an efficient allocation of resources in society (N), given the way in which health care is provided. But this method itself may not be efficient. Suppose that instead of maintaining equal resources and charging each person a fixed premium for amounts of health care that vary with need (since each amount must result in the same final level of health), resources were redistributed so that each could pay for the health care received under the insurance system and have the same resources remaining as if the insurance system were in effect. If equalizing health through an insurance system with equal premiums were efficient, then this redistribution of resources should yield exactly the same outcome; each individual should allocate his or her total resources so that all enjoy the same level of health and the same consumption of other goods. But in fact, those with

very inexpensive health care needs would prefer to divert resources from other goods to obtain an even higher level of health, whereas those with costly health care needs would prefer to divert resources from health care to other goods, accepting a lower level of health. Equalization of levels of health would thus be purchased at the expense of economic efficiency.

Let us turn now to society (R), whose members have equal needs but differing resources. Suppose that its members, like those of society (N), seek to provide equal health care for all. They might maintain the existing social allocation of resources among health care and other goods but redistribute the actual care provided so that all would receive equally. This might be brought about by taxing each person an amount equal to his or her previous expenditure for health care, then providing all persons with identical health care vouchers. But this new state of affairs would be inefficient. The poorer members of the society would prefer to trade some of their vouchers for other goods, whereas the more affluent members would prefer to trade other goods for additional health care. If these trades were to occur, then the new outcome would maintain the optimal social allocation of resources among health care and other commodities. But equality in levels of health would be sacrificed—although the final inequality would be less than the original.

Furthermore, full efficiency would not be attained. For the society's allocation of resources, although optimal given the original distribution of individual resources, might not remain so when these resources are redistributed by the system of taxation and vouchers. It is, however, easy to determine a new optimal allocation. If a market in health care vouchers is allowed, then the initial endeavor to equalize health conditions and health care becomes simply a redistribution that effectively narrows the range of variation among individual resources. We know how each person would allocate expenditures among health care and other commodities given the initial variation in resources; we may therefore determine how each would make this allocation given any narrower variation. Given the range effected by redistribution, we may determine an overall social allocation as the sum of the allocations that individuals would choose. If health care tax and vouchers are then based on this allocation, full efficiency is restored.

But as we noted, although the move to efficiency ensures that all individuals receive their preferred allocations among health care and other commodities, it undercuts the original impetus for equalization. If we seek both equalization of health care and allocative efficiency, then we must effect a complete equalization of resources among all individuals; for only given such equalization will each receive his or her preferred allocation of goods and equal health care. Egalitarianism in health care coupled with economic efficiency yields total egalitarianism in a society such as (R), in which health care needs are

themselves equal. The members of the society, desiring to equalize health care, should simply transfer resources so that equality of expenditure is attained; and let each individual, whose health care needs are *ex hypothesi* the same as those of all others, allocate expenditures as he or she sees fit.

We should emphasize that to this point we have said nothing about the merits of the equalization measures that we have considered. In discussing our two societies we have endeavored solely to trace out the implications of certain equalizing procedures. We turn next to ethical principles for the evaluation of both the initial inequalities in health and the proposed equalizing procedures.

Ethical Analysis

Utilitarianism. We begin our ethical analysis with *utilitarianism*. Let us define *social welfare* as the sum of individuals' utility or well-being. Then a utilitarian ethical procedure prescribes the maximization of social welfare. Utilitarianism is directly concerned with the *production* of social goods; their *distribution* does not enter directly into utilitarian evaluation. However, as has been frequently noted, in practice utilitarianism tends to support an egalitarian distribution of social goods, because the marginal utility obtained from a unit of any good decreases as the total number of units available to an individual increases.

Two principal factors work against this association between utilitarian and egalitarian requirements. The first is the effect of distribution on production. If persons are motivated to produce more by receiving a greater share of the goods produced, and if productive capacity is itself unequally distributed among persons, then a distribution of goods that rewards actual production may increase the sum of social goods sufficiently to increase social welfare above the level that would be achieved by the production of social goods associated with a more egalitarian distribution. In other words, in a utilitarian system the distribution of social goods will be sensitive to incentive effects, although it must be remembered that it is not the total quantity of goods, but their effect on well-being, which is decisive.

The second factor that works against the association of utilitarian and egalitarian requirements is more directly relevant to our present enquiry. The egalitarian effect of utilitarianism depends on the assumption that persons have equal capacities for obtaining utility from resources. If some persons have greater capacity, then they may expect a greater share of goods in a utilitarian system. This implication of utilitarian thought has perhaps been insufficiently discussed by utilitarian theorists, but it is set out with great clarity by John C. Harsanyi. He considers the following example:

Suppose there are two five-year-old boys in my neighborhood. One of them, (A), is a child of very lucky temperament, who seems to be very happy most of the time, and who can derive great joy from minor presents. The other boy, (B), has a rather unlucky temperament. He looks unhappy most of the time, and minor presents seem to give him only little satisfaction. I happen to have a little present in my pocket. Which boy should I give it to?

Utilitarian theory supplies a clear answer to this question: the present should go to that boy who is likely to derive more utility from it. Presumably, this means that it should go to (A), who can be expected to get more immediate enjoyment out of it.⁹

Now we may apply Harsanyi's reasoning in the context of health care. We may suppose that persons derive equal utility from equal degrees of health and that equal resources provide equal amounts of health care. Consider then two persons, one healthy, the other sickly. The ills of the first person are easily curable; the ills of the second are eased little through medical means. In such a case, a given amount of health care will provide a greater benefit, a greater increase in the actual level of health or reduction in deviation from normal human functioning, for the person of basically healthy constitution than for the sickly person. Utilitarianism thus dictates favoring the healthy person, although we may suppose that this leads to a markedly unequal distribution of utility.

However, exclusive attention to this example would oversimplify the real situation. We may expect that the rate at which health care is converted into health, or resources into utility, undergoes marked alterations depending on a person's particular state or condition of health. Although some may exhibit a diminishing marginal capacity to convert health care into health, others may exhibit an increasing marginal capacity; as their conditions improve, further improvements may be much less costly, in terms of resources used balanced against benefits gained.

Now the utilitarian principle does not require that each unit of resources be used in the most effective marginal way, where this is determined without regard to the availability and use of further resources. Consider once again Harsanyi's example. It may be that, by repeatedly giving (B) small presents, his temperament would undergo a marked change and he would become a happier person, getting great enjoyment out of small benefits. Now if resources were severely limited, so that (B) could never receive enough small presents to change his disposition, then indeed utilitarianism would call for giving the

⁹ John C. Harsanyi, *ESSAYS ON ETHICS, SOCIAL BEHAVIOR, AND SCIENTIFIC EXPLANATION*, Reidel, 1976, p. 75.

present to (A). On the other hand, if resources were sufficient to provide a long sequence of small presents, then the overall effect of giving them to (B) might yield greater utility than the overall effect of giving them to (A) or dividing them in some way between (A) and (B). Although to a certain point, each present might afford (B) less immediate utility than it would afford (A), after that point each present might, in altering (B)'s disposition, afford him much greater utility than (A) would at any point receive from a present.

Thus it may be the case that the greater the resources available, the more egalitarian are the implications of a utilitarian ethical principle for the distribution of health care. Indeed, this may be a generalizable conclusion, for both of the factors that make for inequality in utilitarian systems—the effect of distribution on total production and the unequal capacities of persons for obtaining utility from resources—may have their strongest effects under conditions of relative scarcity.

But let us focus more specifically on the application of the principle of maximizing social welfare to the provision of health care in our model societies. We shall assume that the basic structure of each society satisfies utilitarian requirements. This allows us to consider then only the implications for health of applying a utilitarian principle.

In society (N) we have supposed both that all have equal resources and that all have similar preferences. We may therefore represent the requirements of maximizing social welfare by considering the expected utility of a representative individual who knows the health needs of each member of society but is completely uncertain about his or her own needs. This person considers that the likelihood that his or her needs may be identified with those of any one of the n members of society is $1/n$. Suppose that this individual could purchase any health insurance package for its expected cost. That is, if the needs of person i are n_i , then our representative person may choose a health care package with cost c_i to meet those needs, for a premium of c_i/n . This package, of course, benefits him or her only if his or her needs prove to be those of person i . Thus our representative person selects a package appropriate to the needs of each of the members of society, and pays a total premium equal to

$$\sum_{i=1}^n c_i/n.$$

If our representative person chooses rationally, then this overall health care package, consisting of a set of packages one for each member of the society, will maximize his or her expected utility. But his or her expected utility is equal to the average of the utilities of the members of society; and for a fixed group, max-

imizing average utility is equivalent to maximizing the sum of utilities, or social welfare.

The choice must satisfy the following conditions:

(1) Given any set of health care needs, the health care package must be such that one would not benefit by trading any portion of that care, at its actual cost, for any other commodity that that cost would buy, or by trading any commodity for the additional portion of health care that its cost would buy.

(2) Given any two sets of health care needs, the health care packages must be such that the total benefit of shifting resources to increase one and diminish the other would be less than the total cost.

(3) Given any two sets of health care needs, the health care premiums must be such that the total benefit of increasing one and diminishing the other would be less than the total cost (in utility terms).

This third requirement is equivalent to:

(3a) Given any two sets of health care needs, the commodities obtained by the holders of the needs must be such that the total benefit of transferring commodities from one to the other would be less than the total cost.

For in effect a change in premiums corresponds to an inverse change in the amount of other resources available. Now we may suppose that persons with different health care needs are equal in other respects, so that they have similar capacities for converting resources into utility except when health is at stake, and that these capacities exhibit diminishing marginal returns. Thus a transfer of commodities would decrease total utility if it increased inequality in the commodity packages. Hence requirement (3a) is satisfied if the commodity packages are equal, and so (3) is satisfied if the premiums are equal. Hence our representative person would choose a fixed premium with varying health care packages yielding varying total benefits, so that, given the different capacities of persons with differing health care needs to convert resources into health-based utilities, the marginal equivalences needed to satisfy requirements (1) and (2) are met.

The maximization of expected utility in individual choice under conditions of uncertainty will, given our assumptions, maximize social welfare. The requirements of utilitarianism have therefore been related to the requirements of rational choice under special, and indeed highly artificial, circumstances. We shall, however, argue that given the nature of the good of health, such a rational choice may be related to the appropriate ethical basis for the determination of health care.

We note that the choice just considered differs from that involved in equalizing levels of health in society (N). Indeed,

we have identified utilitarianism, not with the choice of an egalitarian system of health care by a representative person, but with the choice of an efficient system. That this efficiency better satisfies our standards of fairness or equity remains to be shown later in our enquiry.

What of the application of the utilitarian principle to society (R)? Here we suppose that the inequalities in the assumed unequal distribution of resources among individuals themselves satisfy utilitarian requirements, reflecting, perhaps, the implications of distribution for production. But then, since individuals are assumed similar in their needs and preferences, overall social welfare is maximized if and only if each individual allocates resources in such a way that individual utility is maximized. Health care poses no special problems, since any inequalities in health conditions that result from individual expenditure patterns in society (R) are simply and directly instances of the more general inequality of resources available to individuals. As long as this more general inequality satisfies utilitarian requirements, then the more particular inequality in health must also satisfy them. Where health care needs are equal and persons do not differ in their capacity to convert resources into utilities, then utilitarianism does not single out health care for special consideration.

Kantian Constructivism. The neo-Kantian ethical theory of John Rawls suggests a very different ethical principle—that the *minimum* level of primary goods received by any individual member of society be *maximized*. Although Rawls develops this principle using a contractual device, we consider his argument to be purely heuristic, and we avoid the contractarian label, which we find misleading. A better term is that suggested by Rawls in his recent Dewey lectures: Kantian constructivism.¹⁰

Kantian constructivism departs notably from the view of individual persons outlined earlier in this essay. It abstracts from all particular differentiating aspects and characteristics of persons; each is regarded as and only as a free and equal rational being, seeking to carry out a life plan embracing the satisfaction of rational desires and the development and expression of a sense of justice. In this view, the primary goods, whether natural or social, are all treated as accidental to the individual. Although society takes as given the distribution of the natural primary goods, the talents, aptitudes, and virtues, yet it regards them, in Rawls's words, "as a common asset," so that all are "to share in the benefits of the distribution whatever it turns out to be."¹¹

¹⁰ John Rawls, *Kantian Constructivism in Moral Theory*, *THE JOURNAL OF PHILOSOPHY*, Vol. 77, No. 10, pp. 515-572.

¹¹ Rawls, *A THEORY OF JUSTICE*, p. 101.

Now Rawls's *maximin* ethical rule—*maximization* of the minimum level of primary goods—naturally follows from this conception of the person as a free and equal rational being. Since persons are strictly distinct one from another, no summation of the goods they receive has ethical significance. Each individual is a separate source of worth and a recipient of separate values. Hence a principle that focuses on distributive considerations, rather than on production, is ethically fundamental. The particular distribution required by the *maximin* rule, egalitarian except where all alike benefit from non-egalitarian practices, follows from the fact that persons are not differentiated by ethically relevant characteristics. The particular differences in talents, aptitudes, and virtues are treated as incidental to the individual, and so as irrelevant to that which alone grounds ethical claims—the basic rationality that is expressed in the formation of a life plan involving the pursuit of rational desires and the expression of a sense of justice. From this ethical standpoint, all life plans, insofar as they embrace these two elements, are of equal worth and afford each individual an equal claim on the goods of society.

Since society is able to affect the distribution of health, even though it is a natural good, the *maximin* rule may be applied to it. Hence, to the extent to which health may be treated independently of other goods, the minimum level of health must be set as high as possible, so that the person who deviates most from natural human functional organization should deviate to the least possible extent. But this requires the strongly equalizing procedures sketched earlier. Health care should be available on a basis that is directly correlated with need so that, insofar as feasible, each individual is brought to the same level of human functioning as his or her fellows.

Of course the good of health is not promoted in strict isolation from other goods; thus the strongly equalizing procedures that would be required were this isolation possible may be rejected because of their adverse effects on the overall level of primary goods afforded to the least advantaged person. Raising the lowest level of health to the maximum extent may be an inefficient means of raising the lowest overall level of primary goods. Thus the allocation of social resources to health care cannot be decided on the basis of the good of health alone. Even when this allocation is determined, we may not simply assume that it is to be used to equalize levels of health insofar as feasible; some persons may be entitled to a higher level of health than their fellows as compensation for a lower level of some other primary good than enjoyed by others. But the strongly egalitarian thrust of Kantian constructivism remains.

In fairness to Rawls, who is the principal contemporary exponent of this ethical theory, we should note that it is unclear how far he would be committed to the argument we have just

outlined. By couching his own argument in terms of the levels of primary goods enjoyed by representative persons, who are thought of in relation to a structure of social roles and institutions, but who are not differentiated in terms of particular needs, Rawls avoids the core problem that we are examining.¹² The maximin rule applies to persons who are thought of as having normal or average needs. But this in effect leaves Rawls with little to say about the problems of equity involved in differentiated health care needs. We have endeavored to show what a Kantian constructivist theory must say, once socially determinable differences in levels of health are treated on a par with other social goods.

We may usefully relate Kantian constructivism to a theory of positive human rights. We say that an individual (x) has a positive right to some good if and only if it is the duty of other persons to ensure that (x) enjoys that good. A person has a positive right to health insofar as it is the duty of others—and so the responsibility of society—to ensure that, within the limits of social feasibility, that person enjoys health; in other words, society ensures that the person's health care needs are met. Since in a theory of positive rights each individual has an equal right to health, it follows that strongly equalizing procedures are ethically required. First we determine the schedule of costs and benefits that relates a health care premium (assumed the same for all persons) to a level of health (also assumed the same for all). Then the choice of a premium and correlative level of health by an individual who commands an equal share of social resources—in other words, the choice sketched earlier—will clearly meet the requirements of equal positive rights to health in a rationally acceptable way.

Libertarianism. The third principle we shall consider forbids all purely redistributive social practices or policies. We may associate it with *libertarianism*, the view that each individual should be free to pursue his or her own good as he or she sees fit, provided that in so doing there is no interference with the similar pursuit by any other person.¹³ The libertarian rejects the claim that individuals have positive rights, defending instead a doctrine of negative rights. A person (x) has a negative right to some good if and only if other persons must avoid acting or interacting with (x) in any way that would lessen (x)'s access to or enjoyment of the good.

From the libertarian standpoint, inequalities of health that arise if health care is treated strictly as a market commodity have no ethical significance in themselves. Whether these inequalities arise because of unequal needs or unequal resources is a matter of indifference. Need is not an ethically relevant

¹² See Rawls, *A THEORY OF JUSTICE*, p. 64, pp. 95-100.

¹³ J.S. Mill's discussion of liberty in Chapter 1 of *ON LIBERTY* suggests the formulation here.

criterion, according to strict libertarian theory. Insofar as a person's access to health care is not impeded, nor the value of the care to which the person has access diminished through the behavior of others or the actions of society, then that person cannot justifiably claim any infringement of his or her right to such health care.

We must of course continue to exclude from this argument, as we have throughout, those health-related conditions directly occasioned by the actions of other persons or of society. If as a consequence of the construction of nuclear-fueled power plants a person's condition of health is worsened through involuntary exposure to radioactive materials, then that person may indeed claim that—unless care is specially provided—the value of the care to which he or she would have access would be diminished, and diminished through the effects of a specific social policy. For the libertarian, it is never sufficient to show that the total benefits of any measure, such as the provision of energy using nuclear fuel, outweigh the total costs of the measure. It is always essential to show that no individual's negative rights are violated by the measure. Individuals have a right to access to health care for needs that are socially occasioned. But there is no parallel right for needs that are naturally based.

In a world of uncertainty, in which persons are unable to ascertain in advance the nature and extent of their health care needs, a system of health care insurance could receive the endorsement of libertarian theorists. But the provision of such insurance in society (N) has no such justification; its rationale, as we noted in introducing it, is entirely an equalizing, redistributive one. Libertarians might wish voluntarily to participate in such an endeavor—it is no part of libertarian thought to deny individuals the right to confer benefits on one another—yet their rights would be violated by any requirement that they do so. Individual entitlements take precedence over redistributions, even if these redistributions are related to needs for a good human life.

The libertarian focuses not on the distribution of commodities but on the acquisition of resources. The basic constraint governing such acquisition is that one may not acquire or establish exclusive right to some resource, if one would thereby worsen the position of those who would no longer be free to make use of that resource.¹⁴ But this constraint has no significant application to access to health care in societies (N) and (R). If the Kantian constructivist endorses the equalizing systems of insurance, the libertarian endorses the original marketplace.

¹⁴ The underlying idea here is formulated by Robert Nozick as the "Lockean proviso"; see his *ANARCHY, STATE, AND UTOPIA*, Basic Books, 1974, pp. 174-182.

Evaluation of Health Care Inequities

From Society's Standpoint. The libertarian argues, quite correctly in our view, that if health care needs are equal, then there can be no reason to give particular attention to inequalities in access to health care services that arise because of differences in individual resources. There is no reason to give health care the status of a right if this would require that it take priority over other commodities preferred by adequately informed persons. Even more, there is no reason to give health care the status of a right if this would require that care for one person would lay a claim on the resources legitimately acquired by other persons. More generally we may say, in agreement with the libertarian, that at least where needs are equal and the availability of resources satisfies general standards of equity, there is no reason to single out access to any good as a matter of special ethical concern. We may of course disagree with the general standard of equity advanced by the libertarian, and we may insist that unequal needs give rise to claims that the libertarian emphasis on negative rights ignores, but we agree at least that access to particular goods, among persons similarly placed with respect to the conversion of resources into those goods, raises no special problems of equity. And we agree not because some general standard of maximizing social welfare is satisfied, but because the particular rights of individual persons would be overridden were commodities such as health care, or goods such as health, to be treated as constraining those individuals in the use of resources.

It may be objected that, in taking this stance, we are ignoring the problem of access to health care that would arise if a person with average health care needs and a fair share of other resources is nevertheless unable to afford what we should consider adequate health care—care sufficient for a reasonable level of human functioning. But we reject this objection. Should the situation arise, it would show that the society as a whole was insufficiently affluent for adequate health care to be generally available, or rather that the society was insufficiently affluent for primary goods as a whole to be available in adequate quantity for all; since if other goods were in sufficient supply, then rational persons would shift the use of their resources to increase their access to health care. But such general social poverty is not a problem in the United States or other industrialized democracies. In a moderately affluent society, any individual with neither exceptional needs nor special problems in converting resources into the primary sources of well-being must be able to provide adequately for himself or herself, as long as the society satisfies our underlying instrumental standard of contributing to the good lives of its individual members. A person unable so to provide, given general affluence, would have had his or her position worsened by the acquisitions of others. A society in which negative rights are

respected leaves all of its members free and able to pursue their good lives.

Thus we agree with the libertarian that, in a society in which health care needs were equal or almost equal, it would be appropriate to treat health care as an ordinary market commodity. There might of course still be a basis for public expenditure on such underlying health-related goods as sanitation and lack of pollution, which are not accessible as private goods in a competitive market. But these further matters fall outside the scope of our present enquiry. Equal need removes equity problems in access to health care services.

From the Individual's Standpoint. However, we part company with the libertarian when we consider the implications of unequal health care needs. If effect, libertarianism rules out measures that affect access to health care whenever these measures would be disadvantageous to any individual, given his or her particular health care needs—where this disadvantage is measured against the provision of health care by purely market means. Now we should argue that, although there is a *prima facie* case for the market provision of any commodity, this presumption may be effectively challenged by an appeal to the underlying idea that society is a “cooperative venture for mutual advantage.” And we hold that in the case of health care the base point from which mutual advantage is to be determined is that provided by the individual, considered apart from the particular chance or accidental factors that determine his or her actual health care needs. In other words, we claim that access to health care should be considered from the standpoint of an individual who makes a reasonable assessment of prospective health care needs, but in the absence of the particular information that would permit knowledge of exactly what those needs are.

Note that this does not lead us to part company from the libertarian in assessing the adequacy of market provision of health care in society (R). For if individuals all have identical needs, then there is no uncertainty involved in making a reasonable assessment of one's needs in the absence of particular information about oneself. The need for this particular information arises only when health care needs differ among members of the society.

In holding that the standpoint of an individual is appropriate for an ethical evaluation of access to health care, we are not embracing the position of the Kantian constructivist. The constructivist abstracts from all individuating characteristics in ethical analysis. We, however, insist on the central importance of individuality and of individual differences in those characteristics we take to be constitutive of the individual person, as a basis for ethical distinctions. It is just because health is *not* such a characteristic, because a person's condition of health is

accidental to his or her identity, that we suppose it appropriate to abstract from actual conditions of health or disease in assessing the fairness of access to health care.

None of us can be said to “deserve” to be the particular person he or she is, or to deserve particular talents, aptitudes, capacities, and virtues. But in taking these characteristics as constitutive of a person’s identity, we in effect agree that a person deserves what follows from these essential features. Although intelligence itself is not deserved, the fruits of intelligence are deserved. Deep philosophical problems lurk in the distinction we have just offered, and they must be put to one side here, noting only that an acceptance of the significance and ethical relevance of ideas of individual desert is part of the value consensus of liberal democratic societies.

Now it is primarily because we hold that persons deserve what follows from their constitutive characteristics, that we reject the general position of the Kantian constructivist. For to suppose that the primary social goods are to be distributed by maximizing the minimum level of such goods is, as John Rawls admits, to treat natural talents, the constitutive characteristics of persons, as a common asset, severing the link between the individual contribution resulting from talents and aptitudes and the goods received in return for that contribution.¹⁵

None of us deserves his or her natural level of health. And since we do not take health to be a characteristic constitutive of individual identity, then none of us deserves what follows from that natural level of health. The fruits of industry or imagination are deserved, but the fruits of epilepsy or blindness are thought of as undeserved, as, if you like, part of a cosmic injustice that it is becoming increasingly possible for society to remedy or compensate. And the desire to effect such remedy or compensation is an evident part of moral feeling, however weak this feeling may be in comparison with other motives to action.¹⁶

Are we then committed to the position of the Kantian constructivist toward health but not other primary goods? Should we endeavor to make health care available in such a way that the minimum level of health enjoyed by any person is maximized? This does not follow. In recognizing the accidental nature of one’s level of health, we do not suppose that each person has a social entitlement to the highest feasible level of health. We suggest only that each is entitled to health care in accordance with his or her particular resources, insofar as these are determined by principles of fair distribution related to the differing characteristics and deserts of individuals, but calculated from a reasonable generalized expectation about health

¹⁵ See Rawls, *A THEORY OF JUSTICE*, p. 101.

¹⁶ For moral feeling, see David Hume, *AN ENQUIRY CONCERNING THE PRINCIPLES OF MORALS*, especially Chapters 5 and 9.

care needs, rather than from whatever information one may have of one's own actual needs. We treat the accidental fortune or misfortune one partakes of as ethically irrelevant, while not letting this irrelevance affect the general distribution of resources in society.

Now we ask, how is it possible to determine an individual entitlement to health care, based on the individual's actual resources but abstracting from his or her actual condition of health? In society (N), in which resources are equal and preferences similar, we may determine this entitlement by considering what any individual would choose as a system of universal health insurance, given that he or she has a $1/n$ chance of having the health care needs of each of the n members of society. But this is to say that each individual is entitled to that level of health care that, given the constraint of equal individual resources, maximizes average expected utility—and so social welfare. The utilitarian procedure developed earlier for society (N) offers the appropriate operationalization of the requirement that health care benefits be linked on the one hand to individual resources and on the other hand to a reasonable general expectation of health care needs.

But we are not embracing the overall utilitarian position in supposing that access to health care should be afforded, not directly through the marketplace, but in accordance with provisions that maximize social welfare. For what is essential, in our view, is that each individual should enjoy access to health care independent of his or her actual condition of health. Access to health care should reflect an impartial concern with the various deviations from natural human functioning that, through no fault of either the individual or society, actually impede the good lives persons might otherwise expect through social cooperation based on individual talents, aptitudes, and interests. To capture this impartiality, we begin with the choice of an individual who has only a reasonably generalized expectation of health care needs; in the simple framework of society (N), this is sufficient to yield a determinate health care entitlement for each.

It is evident that the outcome of this procedure will not be egalitarian. Individuals in society (N) will continue to enjoy significantly different levels of health, reflecting their different needs and more particularly the differential costs of meeting their needs. The health package chosen will be efficient, sacrificing benefits for those conditions most difficult to treat—in the sense that the least expected return is available for the investment of a given quantity of resources, in favor of those conditions that respond more readily to health care. As already noted, differences in the capacity to convert resources into commodities undermine the equalizing tendency of utilitarian

procedures. Efficiency is assured, and to this extent the distribution of health care is responsive to the needs of individuals. But it is the relation between need and the cost of remedy or compensation that is decisive.

In general, the cost-effective supply of any good, although it may meet utilitarian standards, need not satisfy considerations of fairness. To show that a procedure is cost-effective is indeed to show that it provides gains in excess of losses, but it is in general no defense of fairness to show those who have lost out that, had they but been among the winners, they would have enjoyed benefits greater than the costs. The charge of unfairness is a charge against the distribution of benefits and costs, gains and losses, and it can not be met by showing that the aggregate of benefits exceeds the aggregate of costs. But in our particular case, we may defend the utilitarian provision of health care against charges of unfairness by an appeal to the choice procedure that operationalizes it. Any alternative would relate health care to individual needs in a way that would not be chosen by an individual possessed of fair resources and with no knowledge of his or her particular needs. Those who lose out because of their actual health care needs may realize that those needs are accidental, and that they would indeed have chosen the distribution of health care that has resulted in their losing out—had they been unaware of which accident, what deviations from normal functioning, would befall them. If my particular health care needs are not adequately met, it is not so that the needs of others may be met, but rather, so that, whatever my needs might have been, they would be most adequately met on the whole.

Conclusion

We turn in conclusion to relate this abstract discussion of artificially simplified societies to the questions of health care access facing the United States. The inequities in access that we have identified are occasioned not by different resources, but by different needs. The appropriate response to different needs is not, we have argued, to seek to met each need so that the minimum level of health enjoyed is maximized; equally it is not to ignore considerations of need, making ability to pay for health care the only determinant, as it would reasonably be were needs equal. Rather, our argument suggests that cost-effective health care is defensible. In a society in which individual resources were equal, a simple system of universal insurance might suffice. But to suppose that this would equally suffice for our society would be to ignore the historical development of health care services that constrains present options, and the variability and uncertainty of both individual needs and individual resources. There may be no unique way to assure coverage that is available to all, affordable, cost-effective, and com-

prehensive in relation to normal health care needs. But the following points of significance emerge from our discussion.

(1) If both groups have equal health care needs, persons with greater resources may be expected to spend more on health care, and to achieve thereby a higher level of health, than those with lesser resources. If the distribution of resources itself satisfies relevant standards of equity (and we have not attempted here to consider what these would be), this can be no more objectionable in the case of health than in the case of any other good. Our argument reveals no sufficient basis for singling out health for special ethical consideration, other than that afforded by differential need. But this does not impose any strong egalitarian constraint on the availability of health care. We have not considered whether there is a defensible rationale for overall social egalitarianism, but there is no rationale for an egalitarianism limited to health and health care.

(2) Given adequate and available health insurance plans, so that persons can protect themselves against real uncertainties of need, the subsidization of health care costs should be required only for those with substandard resources. Average health costs must be paid by the average person in some manner or other—directly, indirectly through taxation of personal income or expenditure, or even more indirectly through taxation that bypasses individuals but effectively deprives them of income that they would otherwise have received. Although some health-related expenditures may fall appropriately into the class of public goods, we have no reason to treat health care in that category.

(3) The rationale that we have found to underlie any system of health care insurance, or any provision for shared payment of costs, lies in uncertainty of need, which we have not examined here, and in variability of need, which we have argued is ethically significant. Both of these may be most effectively operationalized in the choice of an individual with reasonable expectations but no particular information about need. To such an individual, cost-effectiveness will be of primary concern. But once the demand for health care services is detached from the requirement that these services be provided in a market, cost-effectiveness becomes difficult to maintain. There is a completely rational tendency for persons to make excessive use of health care services (as judged by *ex ante* willingness to purchase such services), since the marginal cost of use may be low or nonexistent.

Competition among health maintenance organizations seeking to offer the most attractive package of health services to the prospective buyer, who views the package in relation to reasonable expectations of need, may be the most effective and palatable way to approach cost-effectiveness in the services provided, and to control excessive use. For such organizations

will have strong incentives not to provide services other than those that would be contracted for by a prospective user who must pay full expected cost.

(4) The provision of health care services that offer relatively small benefits in relation to cost would not be chosen by a rational person seeking to maximize his or her expected health-related benefits but uncertain of particular health care needs. Such a person would not choose to pay the premium for such costly services since, given limited resources, he or she would have to sacrifice other services offering a greater expected return. There is, of course, an understandable tendency to insist that what can be done in the area of health *should* be done, since the benefit to particular persons is very evident. Unfortunately, with the advance of medical technology, we may expect, in addition to many relatively cheap benefits, a proliferation of highly costly benefits, comparable to kidney dialysis. There is no limit to the resources that society might pour into such services. But an unlimited allocation of limited resources to costly medical services is unjustifiable. Our argument shows that it is indeed unfair to provide expensive health services, however much we should like to do so, if less costly services (whether in health or in other areas) affording greater utility for a given expenditure must be sacrificed. We cannot refuse to put a price on health care, because health care services have a price; they utilize scarce resources. A rationing scheme that reflects the *ex ante* preferences and choices of individuals is the only fair way to allocate resources.

(5) We should note that our argument does not require, and indeed opposes, equal access to medical care without regard to age. It is of course true that diminished life expectancy is a central impairment that any system of health care must strive to overcome. But this does not entail that resources should be expended on extended life expectancy in preference to other goods. And in particular, it does not entail that persons should be kept alive in conditions in which natural human functioning is impossible, especially when these persons have enjoyed a period of life corresponding to normal expectancy. Again, we consider the standpoint of an individual comparing the costs of the various benefits he or she would wish to have over a whole life. We may expect a marked difference in the strength of the preference for enjoying a normal life span, and for having life further prolonged; this difference is reasonably operationalized in directing resources primarily against premature death, rather than towards life prolongation. It is therefore reasonable to suppose that each person's entitlement under any universally affordable system of health care will include active life-support therapy only up to a certain age. Beyond that, there can be no objection to the purchase of further life-support therapy by those individuals with sufficient resources and the relevant preferences, but no injustice is thereby done those who do not

receive such therapy. There is no unfairness inherent in the fact that persons die at different ages.

(6) Providing health care is, we have maintained, providing care related to natural human functioning. It is not providing cosmetic care, however desirable this may be. It is not providing abortions for those whose normal functioning is not impaired by pregnancy (which itself must be understood as a natural human condition). Although I should personally favor providing at public expense an abortion for any woman lacking private means who is pregnant as a result of rape or involuntary incest, the argument for such public provision of abortion in non-medically based cases is quite independent from any advanced here. However, the provision of an abortion where pregnancy seriously affects the physical health of the prospective mother is in itself part of any cost-effective and comprehensive health care service. Refusal to include it could be justified only by arguments showing that abortion is incompatible with the status of the fetus; whether such arguments could succeed lies quite outside the present enquiry.

We have argued that fair access to medical care is neither equal access nor market access. Fair access is comprehensive access within the limits set by considerations of cost-effectiveness, but it is not access to non-health-related procedures even if these are performed by medical practitioners. Fair access, since it is related to remedial and compensatory measures for deviations from natural human functioning, is directed primarily at enabling persons to live normal life spans under conditions that enable them to form and pursue reasonable life plans reflecting their talents, aptitudes, and interests. Remedying certain severe defects, however, even if not beyond our technical capacity, may require an excessive and unfair drain on limited resources. Efforts to extend life, however desirable in themselves, may also involve such an excessive drain. Providing services against which one would not choose to insure oneself (given average resources and a general knowledge of health care needs without specific knowledge of one's own condition) is not only *not required* by fair access, but, in diverting resources from preferred uses, is positively *unfair*. The claim of health care needs is the claim that a reasonable and impartial individual, fairly situated in his or her access to resources, would choose to recognize. This is the fundamental conclusion of our enquiry into the ethical dimension of unequal health care needs as affecting fair access to health care.

The Right to a Decent Minimum of Health Care

I

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A consensus that there is a right to (at least) a decent minimum of health care pervades recent policy debates and much of the philosophical literature on health care. Disagreement centers on two issues. Is there a more extensive right than the right to a decent minimum of health care? What is included in the decent minimum to which there is a right?

The common wisdom that there is a right to a decent minimum spans the ideological spectrum of current proposals for reforming the U.S. health care system. Both market-oriented approaches such as Alain Enthoven's Consumer Choice Health Plan (CCHP) and proposals for a National Health Service on the British model assume that there is a right to at least a decent minimum, though some versions of the latter presuppose a more extensive right.¹

Preliminary Analysis

Different theories of distributive justice may yield different answers both to the question "Is there a right to a decent

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¹ Though its author advertises CCHP as "The only practical solution to the soaring cost of medical care," saving dollars is not its only concern. The plan includes several government interventions designed to insure that no one falls beneath a *decent* or *basic* floor of medical service. The specification of items comprising the floor, however, is given no conceptual or theoretical foundation—it merely replicates the list of *basic health services* specified in the HMO Act of 1973. Alain Enthoven, *HEALTH PLAN: THE ONLY PRACTICAL SOLUTION TO THE SOARING COST OF MEDICAL CARE*, Addison-Wesley, Reading, Massachusetts, 1980.

minimum?" and to the question "What comprises the decent minimum?" The justification a particular theory provides for the claim of a right to a decent minimum must at least cohere with the justifications that theory provides for other claims to rights (right-claims). Moreover, the character of this justification will determine, at least in part, the way in which the decent minimum is specified, since it will include an account of the nature and significance of health care needs. To the extent that the concept of a decent minimum is theory-dependent, then, it would be naive to assume that a mere analysis of that concept would tell us whether there is such a right and what its content is. Nonetheless, before we proceed to an examination of various theoretical attempts to ground and specify a right to a decent minimum, a preliminary analysis will be helpful.

Sometimes the notion of a decent minimum is applied not to health care but to health itself, the claim being that everyone is entitled to some minimal level, or welfare floor, of health. I shall not explore this variant of the decent minimum idea because I think its implausibility is obvious. The main difficulty is that assuring any significant level of health for all is simply not within the domain of social control; and what cannot be assured cannot be a right. If the alleged right is understood instead as the right to everything that can be done to achieve some significant level of health for all, then the claim that there is such a right becomes implausible simply because it ignores the fact that in circumstances of scarcity the total social expenditure on health must be constrained by the need to allocate resources for other goods.

Though the concept of a right is complex and controversial, for our purposes a rather simple sketch will do. To say that a person (A) has a right to something, (X), is first to say that (A) is entitled to (X), that (X) is due to him or her. This is not equivalent to saying that if (A) were granted (X) it would be a good thing, even a morally good thing, nor that (X) is desired by or desirable for (A). Second, it is usually held that valid right-claims may be backed by sanctions, including coercion if necessary, and that (except perhaps in cases where rights conflict or in some exceptional circumstances) failure of an appropriate authority to apply the needed sanctions is itself an injustice. Recent rights-theorists have also emphasized a third feature of rights, or at least of rights in the strict sense: Valid right-claims "trump" appeals to what would maximize utility, whether it be the utility of the right-holder or social utility.² In other words, if (A) has a right to (X), then the mere fact that infringing (A)'s right would maximize overall utility or even (A)'s utility is not itself a sufficient reason for infringing (A)'s right.

² Ronald Dworkin, *TAKING RIGHTS SERIOUSLY*, Harvard University Press, Cambridge, Massachusetts, 1977, pp. 184-205.

I think it is fair to say that many who confidently assume there is a right to a decent minimum of health care have failed to appreciate the significance of the first feature of our sketch of the concept of a right. It is crucial to observe that the claim of a right to a decent minimum is much stronger than the claim that everyone ought to have access to such a minimum, stronger than the claim that if they did it would be a good thing, stronger than the claim that any society capable, without great sacrifice, of providing a decent minimum but failing to do so is deeply morally defective. None of the latter assertions implies the existence of a right, if this is understood as a moral entitlement that should be established by the coercive power of the state if necessary. This simple point finds expression in traditional ethical theories and in our ordinary moral discourse, for in both a distinction is made between "ought" judgments that express claims of right and judgments that express imperatives founded on moral virtues other than justice. In particular, a distinction is drawn between imperatives of justice and imperatives of charity (or beneficence or generosity), the assumption usually being that only the former may be enforced.

It is also important to notice that the difference between the judgment that we ought to provide (X) to (A) and the judgment that (A) has a right to (X) is not a difference between different degrees of strength or constancy in our moral convictions. To the morally virtuous person the imperatives of charity may be as urgent as those of justice. This point has troubling implications for attempts to establish right-claims by the use of what John Rawls calls "the method of reflective equilibrium."³ According to this method, we appeal to our particular considered moral judgments as provisional data to be accounted for and organized by a smaller set of more general moral principles. The difficulty is that we may be much surer that someone ought not to lack a certain form of health care than we are about whether the ground of this judgment is a principle that structures our sense of justice or our sense of charity (or beneficence or generosity). And even if we can show what makes health care, or certain kinds of health care, morally important, this will not in itself show a right to health care, unless the appropriate connection with principles of justice can be made.

Another point of clarification is in order: The right-claim we shall be examining is a universal right-claim—one that attributes the same right to all persons. Special right-claims, in

³ For an attempt to break the deadlock of conflicting intuitions between those who believe there are moral welfare rights (such as Rawls) and those who do not (such as Nozick), see Allen Buchanan, *Deriving Welfare Rights from Libertarian Rights*, in *INCOME SUPPORT: CONCEPTUAL AND POLICY ISSUES*, edited by Peter G. Brown, Conrad Johnson, and Paul Vernier, Rowman and Littlefield, Totowa, New Jersey, 1981, pp. 233-245.

contrast, restrict the right in question to certain individuals or groups.

At least three types of arguments might be given for special rights to health care. First, there are arguments that past or present institutional injustices must be rectified. It could be argued, for example, that American Blacks and Native Americans are entitled to a certain core set of health care services because of their history of unjust treatment at the hands of the U.S. government, on the grounds that these injustices have directly or indirectly had detrimental effects on the health of those groups. Second, there are arguments that compensation is owed to those who have suffered unjust harm or who have been unjustly exposed to health risks by the assignable actions of private individuals or corporations—for instance, those who have suffered neurological damage from the effects of chemical pollutants.

Third, a strong moral case can be made for special rights to health care for those who have undergone exceptional sacrifices for the good of society as a whole—in particular those whose health has been adversely affected through military service. The most obvious candidates for such compensatory special rights are soldiers wounded in combat. As a universal right, the right to a decent minimum is distinct from special rights of any of these three sorts.

Further, the right to a decent minimum is typically understood as being more extensive than a right to those traditional public health services that are usually justified on the grounds that they are required to protect the citizenry from certain harms arising from the interactions of persons living together in large numbers. Examples of such services include public sanitation and immunization. Though a (universal) right to a decent minimum would presumably include such services, it is generally assumed that it would also include a set of personal medical services designed to protect or enhance the health of the individual independently of its salutary effects on the health of others.

The Case for a Decent Minimum

Rights-Based, Prudential, and Equal Protection Arguments. It is illuminating to consider the surprisingly broad scope of health care coverage that would result if services called for by the various special health care rights discussed above were combined with services grounded in what may be called *prudential* arguments. For example, it has often been argued that certain basic forms of health care make for a more productive labor force or improve the fitness of the citizenry for national defense. An even more obvious prudential case can be made for traditional public health measures undertaken to pre-

vent the spread of disease. In neither case does the argument assume that individuals have moral rights (whether special or universal) to the services in question.

The prudential argument for traditional public health services, however, may be elaborated in a way that brings it closer to arguments for a universal right to health care. With some plausibility one might contend that once the prudential case has been made for expending public resources on public health measures, there is a moral (and perhaps constitutional) obligation to achieve some standard of *equal protection* from the harms these measures are designed to prevent. Such an argument would imply that the availability of basic public health services should not vary greatly across different racial, ethnic, or geographic groups within the country.

It seems very likely that combining arguments for various special health care rights with prudential arguments for basic health services and an argument for equal protection through public health measures would do a great deal toward satisfying the health care needs of most concern to those who advocate a universal right to a decent minimum. In other words, once the strength of a more pluralistic approach is appreciated, we may come to question the popular dogma that policy initiatives designed to achieve a decent minimum of health care for all must be grounded in a universal moral right to a decent minimum. This suggestion is worth considering because it again brings home the importance of the methodological difficulty encountered earlier. Even if, for instance, there is wide consensus on the considered judgment that the lower health prospects of inner-city Blacks are not only morally unacceptable but also an injustice, it does not follow that this injustice consists of the infringement of a universal right to a decent minimum of health care. Instead, the injustice might lie in the failure to rectify past injustices or in the failure to achieve public health arrangements that meet a reasonable standard of equal protection.

Appeal of the "Decent Minimum" Concept. At least three features widely associated with the idea of a right to a decent minimum, together with the facile consensus that vagueness promotes, help explain the popularity of this idea. First, it is usually and quite reasonably assumed that the idea of a decent minimum is to be understood in a society-relative sense. Surely it is plausible to assume that, as with other rights to goods or services, the content of the right must depend upon the resources available in a given society and perhaps also upon a certain consensus of expectations among its members. So the first advantage of the idea of a decent minimum, as it is usually understood, is that it allows us to adjust the level of right-based services to be provided to relevant social conditions; it also allows for the possibility that the floor provided by the decent minimum should be raised as a society becomes more affluent.

Second, the idea of a decent minimum avoids the excesses of what has been called the strong equal-access principle, while still acknowledging a substantive universal right. According to the strong equal-access principle, everyone has an equal right to the best health care services available. Aside from the weakness of the justifications offered in support of it, the most implausible feature of the strong equal-access principle is that it forces us to choose between two impalatable alternatives. We can either set the publicly guaranteed level of health care lower than the level that is technically possible, or we can set it as high as is technically possible. In the former case, we shall be committed to the uncomfortable conclusion that no matter how many resources have been expended to guarantee equal access to that level of services, individuals are forbidden to spend any of their resources for additional services not available to all. Granted that individuals are allowed to spend their after-taxes incomes on more frivolous items, why shouldn't they be allowed to spend it on health? If the answer is that they should be so allowed, so long as this does not interfere with the provision of an adequate package of health care services for everyone, then we have retreated from the strong equal-access principle to something very like the principle of a decent minimum. If, on the other hand, we set the level of universal guaranteed services so high as to eliminate the problem of persons seeking extra care, this would produce a huge drain on total resources, foreclosing opportunities for producing important goods other than health care.

So both the recognition that health care needs must compete with other goods and the conviction that beyond some less-than-maximal level of publicly guaranteed services individuals should be free to purchase additional services point toward a more limited right than the strong equal-access principle asserts. Thus the endorsement of a right to a decent minimum may be more a recognition of the implausibility of the strong right to equal access than a sign of any definite position on the content of the right to health care.

A third attraction of the idea of a decent minimum is the intuitively plausible suggestion that, since the right to health care must be limited in scope (to avoid the consequences of a strong equal-access right), it should be limited to the most basic services, those normally adequate for health, or for a decent or tolerable life. But while this aspect of the idea of a decent minimum is useful because it calls attention to the fact that health care needs are heterogeneous and must be assigned some order of priority, it does not itself provide any basis for determining which are most important.

The three features that make the concept of a right to a decent minimum of health care attractive also suggest its inadequacy in the absence of a coherent and defensible theory of

justice. Indeed, when taken together they do not even imply a right to a decent minimum. Rather, they only support the weaker conditional claim that if there is a right to health care, then it is more limited than the right of strong equal access, and its content depends upon both available resources and a scheme of priorities showing certain health services to be more basic than others. It appears, then, that a theoretical grounding for the right to a decent minimum of health care is indispensable.

Has the Right to a Decent Minimum Already Been Established? Before we examine several contending principles or theories of justice and their implications for the claim that there is a right to a decent minimum, let us consider an attempt to circumvent this onerous enterprise. It might be thought that nothing so foundational is required as an attempt to ground the right to a decent minimum and to specify its content by presenting and defending a normative theory of justice. Policymakers need not seek moral bedrock; they can build on those normative assumptions that enjoy a high degree of social consensus and are embodied in the historically evolved institutions of their society. One might argue, therefore, that the right to a decent minimum has been established in our society, if not explicitly in the Constitution, then in the accretion of legislative enactments and administrative law of the past several decades. Federal and state entitlement programs have generated expectations that have not only legal but also moral weight. And though there may be disagreement as to the precise boundaries of the moral claims engendered by these institutions, the least that can be said is that they include the right to a decent minimum. Moreover, since our institutions are democratic, these expectations have all the more moral weight because they issue from social consensus.

This attempt to avoid the task of constructing and evaluating a theoretical basis for the claim of a right to a decent minimum fails for two reasons. First, it is insufficiently critical in its employment of the notions of "social consensus" and "democratic institutions." Granted that there are explicit and significant constitutional restrictions on the principle of majority rule and granted that a wide range of institutional, social and economic barriers to equal participation in the legislative and administrative processes have created the current web of legal health care entitlements, the claim that these are as a whole the expression of the will of the majority should be met with icy skepticism.

Second, even if they enjoy the support of the majority, whether or not the expectations generated by a set of institutional arrangements have any significant moral weight must surely depend upon whether the institutional system in question meets some minimal standard of justice. And even if the

existing institutional system is minimally just, and the expectations it generates therefore have some moral weight, we are still faced with the question of whether to perpetuate the processes by which these expectations are generated or to reform or replace them. (This is not to deny, of course, that reform of the current system, if it is warranted, should include transitional measures that give due consideration to the expectations it has hitherto supported.) For both of these reasons, then, it appears that the task of examining attempts to ground a right to a decent minimum in a normative theory of justice cannot be evaded. On the other hand, once such a right is established, an appeal to institutionally supported expectations may help specify the content of the decent minimum.

In the remainder of this essay I will consider in turn the following approaches to justifying and specifying a (universal) right to a decent minimum of health care:

- (1) arguments that health care is a necessary condition for the effective exercise of other rights;
- (2) utilitarian arguments;
- (3) Rawlsian ideal contractarian arguments; and
- (4) arguments from equality of opportunity.

I will also consider (5) an argument for an enforceable principle that requires a decent minimum of health care for all but does not presuppose a right to health care. I shall argue that if this non-rights-based approach is combined with arguments for special (as opposed to universal) rights to health care, and with familiar prudential arguments for public health measures, the result is a strong moral case for a legal entitlement to an extensive set of health care services, even if there is no universal moral right to health care.

“Conditional” Arguments. Sometimes a right to health care is advocated on the grounds that at least some minimal level of health is a necessary condition for the effective exercise of basic civil or political rights. This argument has two quite distinct variants. The first may be called “the instrumental public interest argument” and is closely related to a familiar argument purporting to justify a universal right to a basic education on the grounds that informed participation in the political process is in the public interest. Similarly, it is argued that at least some basic level of health care ought to be provided as a matter of right, both to allow as many as possible to participate vigorously in public affairs by removing barriers due to poor health, and to allow as many as possible to exercise efficiently the right to an education, where the function of the latter right is to assure informed political participation.

The second version may be called “the fair procedures argument.” The main premise is that—because it is essentially

a monopolistic set of procedures—a state-enforced system of civil and political rights not only confers benefits but also imposes burdens of restraint upon citizens, and that the distribution of these burdens should be fair. The clearest application may be to the various rights of due process. The system of legal rights is monopolistic in the sense that it specifies that one may pursue or protect one's interests only in certain prescribed ways. For example, if you steal my property or defraud me, I must rely upon the courts rather than upon my own strength or cunning, or that of my friends, to regain what I have lost. On pain of coercion, the system forbids me to protect my interests in ways other than those it prescribes.

But if some citizens are consistently able to use the legal system to protect their interests much more effectively than other simply because of their superior education or wealth, then the burdens of restraint imposed by the system fall inequitably. To put it simply: If the rules of the game are such that to have a fighting chance one must have certain equipment, if it is the only game in town, and if one's most basic interests depend upon one's ability to play the game effectively, then it is unreasonable to expect that those who (by accidents of birth and fortune) lack the requisite equipment should bear the burden of restraint imposed by the rules of the game.

This argument may provide the beginning of a justification for a right to certain forms of publicly subsidized education or legal services. Does it also provide an argument for a right to health care?

One can certainly think of cases where certain health impairments—such as deafness or the inability to speak in one's own behalf at a trial—might put one at such a disadvantage in the socially prescribed procedure for conflict-resolution that it would be plausible to say the procedure was unfair to the impaired person. Yet it would not follow that attempts to eliminate or minimize this unfairness would ground a right to even a minimum of health care since it might be more efficient to provide other services (such as competent legal counsel, along with sign-language interpreters in the present example), and these only for the duration of the individual's participation in the legal process. So even if it is true that the dominant social procedures for conflict-resolution impose inequitable restraints on some who suffer from certain forms of ill-health, this seems an inadequate foundation for a broad set of universal basic health services.

Similarly, though it is certainly true that, as the first argument states, ill-health is a barrier to active political participation, wider political participation might be achieved more effectively and cheaply by other means than the provision of health care. For example, allowing workers time off with pay for participation in political campaigns or political decisionmak-

ing might prove more efficient. In sum, it seems that arguments for enabling the effective exercise of basic civil and political rights may provide a plausible case for a right to education, legal aid, and perhaps in some cases even certain health services; but these arguments do not provide a firm basis for what we intuitively regard as a universal right to a decent minimum of health care.

Perhaps more importantly, even where such arguments do support a right to health services, they do so for the wrong reasons. For surely the right to health care, if it exists, is based on other, more direct considerations. The arguments considered above seem to trivialize health care. To put it bluntly, the primary reason I need relief from the excruciating pain in my abdomen is surely not that its presence may distract me from pulling the right lever in the voting booth.

Utilitarian Arguments. Utilitarianism purports to be a comprehensive moral theory, of which a utilitarian theory of justice is only one part. There are two main types of comprehensive utilitarian theory: *act utilitarianism* and *rule utilitarianism*. Act utilitarianism defines rightness by reference to particular acts: An act is right if and only if it maximizes utility. Rule utilitarianism defines rights by reference to rules of action and makes the rightness of particular acts depend on the rules under which those acts fall. A rule is right if and only if general compliance with that rule (or with a set of rules of which it is an element) maximizes utility, and a particular action is right if and only if it falls under such a rule.

Both act and rule utilitarianism may be versions of either classic or average utilitarianism. *Classic utilitarianism* defines the rightness of acts or rules as *maximization of aggregate utility*; *average utilitarianism* defines rightness as *maximization of utility per capita*. The aggregate utility produced by an act or by general compliance with a rule is the sum of the utility produced for each individual affected. Average utility is the aggregate utility divided by the number of individuals affected. "Utility" is defined as pleasure, satisfaction, happiness, or the realization of preferences, as the latter are revealed through individuals' choices.

The distinction between act and rule utilitarianism is important for a utilitarian theory of justice, since the latter must include an account of what makes institutions just. Institutional rules may maximize utility even though those rules do not direct individuals (either as individuals or as occupants of institutional positions) to maximize utility in a case-by-case fashion. For example, a judicial system that maximizes utility may do so by including rules that prohibit judges from deciding a case according to their estimates of what would maximize utility in that particular case. So the utilitarian justification of a particular action or decision may not be that it maximizes

utility, but rather that the institutional rule under which it falls maximizes utility.⁴

Some utilitarians, such as John Stuart Mill, hold that principles of justice are the most basic moral principles because the utility of adherence to them is especially great. According to this view, utilitarian principles of justice are those utilitarian moral principles of such importance that they may be enforced, if necessary. Some utilitarians, including Mill perhaps, also hold that among the utilitarian principles of justice are principles specifying individual rights where the latter are thought of as enforceable claims that take precedence over appeals to what would maximize utility in the particular case. Indeed, some contemporary rights theorists such as Ronald Dworkin define a (justified) right-claim as one that takes precedence over mere appeals to what would maximize utility.

A utilitarian moral theory, then, can include rights principles which themselves prohibit appeals to utility maximization, so long as the justification of those principles is that they are part of an institutional system that maximizes utility. In cases where two or more rights principles conflict, utility considerations may be invoked to determine which rights principles are to be given priority. Utilitarianism is incompatible with rights only if rights exclude appeals to utility maximization at all levels of justification, including the most basic institutional level. Rights founded ultimately on considerations of utility may be called *derivative*, to distinguish them from rights in the strict sense.

If by a right we mean a right in the strict sense, i.e., a claim that takes precedence over mere appeals to utility at all levels, including the most basic institutional level, then utilitarianism denies the existence of rights in general, including the right to a decent minimum of health care. If, on the other hand, we mean by right a claim that takes precedence over mere appeals to utility at the level of particular actions or at some institutional level short of the most basic, but which is justified ultimately by appeal to the utility of the total set of institutions, then utilitarianism does not exclude and indeed may even require rights, including a right to health care. Whether or not the total institutional array that maximizes utility will include a right to health care will depend upon a wealth of empirical data not deducible from the principle of utility itself.

A utilitarian system of (derivative) rights would pick certain goods as making an especially large contribution to the maximization of utility. And it is reasonable to assume that health care—or rather, certain kinds of health care—is among

⁴ Allen Buchanan, *Justice: A Philosophical Review*, in *JUSTICE AND HEALTH CARE*, edited by Earl E. Shelp, Dordrecht, Holland, 1980, pp. 3-21.

them. Consider, for example, perinatal care, understood broadly as including genetic screening and counseling (at least for special-risk populations), prenatal nutritional care and medical examinations for expectant mothers, medical care during delivery, and basic pediatric services in the first crucial months after birth. If empirical research shows (1) that institutional arrangements that maximize utility would include such services because they have such a profound impact on the individual's lifelong capacity for happiness, and (2) that these services would be best assured if they were granted the status of a right, with all that this implies, including recourse to coercive sanctions if needed, then according to utilitarianism there is such a right.

Further, the strength of this right relative to other (derivative) rights will also be determined by empirical research concerning the utility of the health care in question compared with the utility of the goods assured by other rights. Granted that this is so, it may seem impossible to determine, even for our society at the present time, the specific items that would be included in a utilitarian-based right to health care, without first having at least a rough sketch of the different amounts of utility to be gained from alternative schemes for allocating resources across all sectors of the economy. It may appear, then, that the most we can say is that it is very likely that utilitarianism would support a right to some forms of health care, especially those relatively inexpensive primary care services and preventative services that have the most profound long-term effects on the individual's happiness; but it is likely that utilitarianism would limit the right to health care in ways that reflect the fact that health is not the only source of utility. Thus it might appear that utilitarianism can at present do little to clarify the popular but vague notion that there is a right to a decent minimum of health care.

This pessimistic conclusion may be premature. First, utilitarianism does provide an advance over the popular notion of a right to a decent minimum insofar as it (1) offers a clear answer to the question of *what* it is about health needs that grounds the right to health care, (2) provides (in principle) a *method* for determining what the content of the right is, and (3) explains why the right to health care is a right to a *minimum*: i.e., it tells us why we ought to reject the idea of a strong equal-access right. Second, there is the fact that for the utilitarian, empirical research is needed to determine not only whether some set of health care services is to be provided as a right, but also whether the right is to be an equal right, i.e., a right ascribed to all. This last crucial feature may provide a way of evaluating the utilitarian position on the right to a decent minimum without completing the staggering task of sketching a comprehensive utilitarian theory of rights.

Utilitarians typically argue that a given right should be an equal or universal right on the grounds of the diminishing marginal utility of the good in question. In the case of some important goods, such as food, clothing, and shelter, it is plausible not only to assume that these items have diminishing marginal utility for everyone, but also that overall utility will be maximized if, for purposes of calculation, we proceed as if the threshold at which marginal utility begins to decline and the rate of its decline are the same across the whole population. The idea is that though there are differences in the marginal utility curves of individuals, we do not have accurate knowledge of them, and at any rate they tend to cancel each other out. The difficulty is that health needs are much more heterogeneous than needs for food, shelter, or clothing, and that for many individuals there is virtually no limit to the beneficial expansion of health services, granted continued technological advances.

The recognition that it may be difficult to argue for equal health care rights on utilitarian grounds has led utilitarian theorists to speculate on unequal utilitarian (derivative) rights to health care, but they have sometimes come to opposite conclusions. A. K. Sen has argued that utilitarianism would require us to allocate fewer resources to the disabled because they would gain less utility from those resources than would normal persons, whose range of opportunities for enjoyment is not so restricted.⁵ If Sen is correct, then certain health services that might be accorded the status of rights for all "normal" (non-disabled) people would not be established as rights for the disabled. This general result is still compatible, of course, with the thesis that utilitarianism provides a basis for a universal right to a decent minimum of health care, unless it can be shown that under some circumstances utility would be maximized by providing no health services whatsoever to certain classes of people (as a matter of right) or at least none substantial enough to warrant the label "a decent minimum." It is important to note that the class of the disabled here is not limited to those who are so impaired as to be incapable of virtually all enjoyments, e.g., those who are in a persistent vegetative state.

Richard Brandt⁶ has argued that Sen's conclusion is incorrect. Brandt reasons as follows. If, for purposes of simplification, the task is to allocate a certain sum of dollars between two persons, (A) and (B), so as to maximize overall utility, we should divide the sum so that the marginal (i.e., incremental)

⁵ A.K. Sen, *ON ECONOMIC INEQUALITY*, W.W. Norton, New York, 1973, p. 16.

⁶ Richard Brandt, *A THEORY OF THE RIGHT AND THE GOOD*, Oxford, Clarendon Press, 1979, pp. 318-319.

benefits for (A) and (B) are equal. Now if (A) is disabled while (B) is not, it will presumably take more resources to bring (A) up to the "break-even point"—i.e., the point where the individual's happiness exceeds his unhappiness. Beyond that point, however, the utility curves of the normal person (B) and the disabled person (A) will be virtually identical in shape. But this means that (B)'s *marginal* benefit will equal (A)'s *marginal* benefit only if the sum to be allocated is divided so that (A), the disabled person, gets more than (B), the normal person. So utilitarianism requires that we be more generous to the worse-off, not less generous, as Sen thought. Brandt offers this as an argument for special cash or in-kind supplements for the disabled. His position is apparently that utilitarianism would require such supplements in addition to a universal right to some minimal income-share, where the assumption is that the normal population would be able to purchase an adequate minimum of health services (along with other important goods) with these income-shares.

It seems that both Sen and Brandt have over-generalized. Without detailed empirical data it is impossible to say whether utilitarianism would provide a particular class of those in ill-health with a particular set of services as a matter of right, and the answer will vary from class to class and from service to service. Brandt assumes (1) that a rather small special allocation will be required to bring the disabled person up to the threshold at which significant gains in utility begin (the break-even point), and (2) that there will be little or no uncertainty as to the efficacy of the special allocation. He also seems to assume (3) the normal person's marginal utility begins to diminish at a rather low level of resources. Where all of these conditions hold, utilitarianism may require special supplements to the worse-off for the reasons Brandt cites; and granted that these circumstances do sometimes occur, Sen's generalization fails. But in situations in which one or more of these assumptions is not satisfied, maximizing expected utility may require allocating a larger share, or even the total available resources, to the normal person.

Further, both Brandt and Sen indulge in two misleading simplifications. First, they consider the effects of an allocation only upon the individual who receives it. Yet utilitarianism requires that we select that allocation that maximizes expected net utility for the entire set of individuals affected by it, whether directly or indirectly. This simple fact complicates the picture enormously, making it even less plausible to advance generalizations of the sort offered by Brandt and Sen. Thus, whether utilitarianism would require a special supplement for persons suffering from a particular disability (Brandt) or would require that they be excluded from some or all of the services normal persons receive (Sen) will depend not only upon the three variable factors listed above, but also upon the expected

contributions the persons in the two groups will make to the utility of others.

So far it seems we can only conclude that it is very implausible to project a general utilitarian policy in response to the heterogeneity of health needs. It may be possible, however, to draw some sharper conclusions by focusing on a specific class of the disabled.⁷ Even if utilitarianism would provide a decent minimum of services (or a portion of an individual income share designed to purchase such a minimum) for all non-disabled or "normal" persons, and even if it would also provide special supplements for certain disabled populations, would it guarantee some core set of services for everyone? The following example suggests that it is doubtful that utilitarianism provides a firm basis for a universal right to a decent minimum. Consider the class of Down's syndrome newborns. Many of these retarded individuals suffer cardiovascular or gastrointestinal defects that are life-threatening if not corrected by surgery. Further, most Down's syndrome individuals require a large expenditure of social resources over a lifetime—either they are institutionalized or they are maintained at considerable cost through the efforts of their families, often with the aid of publicly funded social services. Moreover, it can be argued that compared with these costs the contribution these individuals make to social utility is not large, at least so far as we must work with a conception of contribution that is in some way quantifiable. If all of the preceding claims are granted, a strong utilitarian case can be made for excluding Down's syndrome infants from the minimal health services guaranteed as a right to the rest of the population.

It might be objected that such a policy would not maximize utility because, granted fallibility in its administration and granted a public awareness of this fallibility, a great deal of disutility would be generated in the form of anxiety over the prospect of "false positives" in the process of selecting those who are to be excluded from the decent minimum.

This reply is weak because membership in the excluded class can be reliably ascertained from birth and because those who understand enough to dread being misclassified have virtually nothing to fear. Further, if the policy were applied only to newborn Down's individuals, disutility to family members would be minimized because attachments would not yet be developed.

It should be noted that the individuals referred to in this example are capable of various enjoyments and would benefit greatly from the services from which they are to be excluded. We are not speaking, say, of anencephalic babies, to whom the

⁷ I am indebted to Daniel Wikler for this point.

very notion of "interests" has at best a tenuous application. This feature of the example is crucial because it highlights the fact that utilitarianism may require that even for the most basic health services, what is guaranteed as a right to one individual may not be provided to another, even though their needs are equal and even though both would benefit greatly from the services. Notice also that this does not apply only to exotic or even expensive services. Granted the facts about Down's newborns, maximizing utility may dictate that we adopt a uniform policy of providing virtually no services to these individuals. The unreliability of a selective policy may simply be too great, due to the difficulty of predicting at birth the adult's degree of impairment, even if some Down's infants would grow up to make a net contribution to social utility. Finally, if a uniform exclusionary policy were supported by a public education program that made clear the reliable utilitarian calculations that led to the selection of this special class, there would be no reason to assume that this decision would lead us down a "slippery slope" to wholesale euthanasia.

My purpose in developing this example in detail is not to show conclusively that there are no circumstances or no likely circumstances in which utilitarianism would support a (derivative) universal right to a decent minimum of health care. Instead I have only shown that, granted certain plausible assumptions that may in fact now be satisfied in our society, there is good reason to doubt that utilitarianism provides a secure foundation for such a right.

Ideal Contractarian Argument (Rawls). In *A THEORY OF JUSTICE* and subsequent essays John Rawls develops a sophisticated new version of the traditional theory of the social contract as a systematic alternative to utilitarianism.⁶ According to Rawls, correct principles of justice are those that would be chosen by rational individuals in a choice-situation (or "original position") that is fair in the sense that it is structured to eliminate biasing factors that would enable someone to choose principles that would be to his or her special advantage. Rawls argues that the principles that would be chosen in the original position are as follows.

(1) *The principle of greatest equal liberty:* Each person is to have an equal right to the most extensive set of basic liberties compatible with a similar system of liberty for all (the basic liberties include the most important civil and political rights recognized by the U.S. Constitution).

(2) *The principle of fair equality of opportunity:* Offices and positions are to be open to all under conditions of fair equality of opportunity; persons with similar abilities and mo-

⁶ John Rawls, *A THEORY OF JUSTICE*, Belknap Press of the Harvard University Press, Cambridge, Massachusetts, 1971.

tivation are to have similar prospects of obtaining offices and positions.

(3) The *difference principle*: Social and economic institutions are to be arranged so as to benefit maximally the worst-off.

Since the demands of these principles may conflict, Rawls offers a way of ordering them. Principle (1) is lexically prior to principle (2) and principle (2) is lexically prior to principle (3). A principle (P) is lexically prior to a principle (Q) if and only if we satisfy all the requirements of (P) before attending to the requirements of (Q); i.e., lexically prior principles take absolute priority.

Rawls notes that “[M]any kinds of things are said to be just or unjust: not only laws, institutions, and social systems, but also particular actions . . . decisions, judgments and imputations . . . ”⁹ But he insists that the primary subject of justice is the basic structure of society because it exerts a pervasive and profound influence on the individual’s life prospects. The basic structure is the entire set of major political, legal, economic, and social institutions. In our society the basic structure includes the Constitution, private ownership of the means of production, competitive markets, and the monogamous family. The basic structure plays a large role in distributing the burdens and benefits of cooperation among members of society.

If the primary subject of justice is the basic structure, then the primary problem of justice is to formulate and justify a set of principles that a just basic structure must satisfy. These principles will specify how the basic structure is to distribute prospects of what Rawls calls “primary goods.” These include the basic liberties listed above under principle (1), as well as powers, authority, opportunities, income, and wealth. Rawls says that primary goods are things that every rational person is presumed to want, because they normally have a use, whatever a person’s rational plan of life. Principle (1), the principle of greatest liberty, regulates the distribution of prospects of basic liberties. Principle (2), the principle of fair equality of opportunity, regulates the distribution of prospects of powers and authority, so far as these are attached to institutional offices and positions. Principle (3), the difference principle, regulates the distribution of prospects of the other primary goods, including wealth and income. Though the first and second principles require equality, the difference principle allows inequalities so long as the total system of institutions of which they are a part maximizes the prospects of the worst-off for the primary goods in question.

Though Rawls offers several arguments to show that his principles would be chosen in the original position, the most

⁹ *Ibid.*, p. 7.

striking is the *maximin* argument. According to this argument, the rational strategy in the original position is to choose that set of principles whose implementation will maximize the minimum share of primary goods that one can receive as a member of society, and the above three principles will insure the greatest minimal share. Rawls claims that because these principles protect one's basic liberties and opportunities and insure one of an adequate minimum of goods such as wealth and income (even if one should turn out to be among the worst-off), the rational thing is to choose them, rather than to gamble with one's life prospects by opting for alternative principles. In particular, Rawls contends that it would be irrational to reject his principles and allow one's life prospects to be determined by what would maximize utility, since utility maximization might allow severe deprivation or even slavery for some, so long as this contributed sufficiently to the welfare of others.

According to Rawls, the question of whether there is a right to a decent minimum of health care, like all other questions concerning rights, is to be answered ultimately by appeal to those principles of justice that would be chosen in the original position (choice-situation). However, no principle explicitly specifying a right to health care is included among Rawls's principles of justice. Further, since those principles are intended to regulate the basic structure of society as a whole, they are not intended to guide the decisions individuals make in particular health care situations, nor are they even to be applied directly to health care institutions. We are not to assume that either individual physicians or administrators of particular policies or programs are to attempt to allocate health care so as to maximize the prospects of the worst-off. In Rawls's theory, as in utilitarianism, the rightness or wrongness of particular actions or policies depends ultimately upon the nature of the entire institutional structure within which they exist. Hence, Rawls's theory can provide us with fruitful answers at the micro-level only if its implications at the macro-level are adequately developed.

If Rawls's theory includes a right to health care, it must be a right in some way derivative of the basic rights laid down by the principle of greatest equal liberty, the principle of equality of fair opportunity, or the difference principle. And if there is to be such a derivative right to health care, then health care must either be among the primary goods covered by the three principles or it must be importantly connected with some of those goods. Now at least some forms of health care (such as broad services for prevention and health maintenance, including mental health) seem to bear the earmarks of Rawlsian primary goods: They facilitate the effective pursuit of ends in general and may also enhance our ability to criticize and revise our conceptions of the good. Nonetheless, Rawls does not explicitly

list health care among the social primary goods included under the three principles.

Let us suppose that health care is either itself a primary good covered by the difference principle or that health care may be purchased with income or some other form of wealth that is included under the difference principle. In the former case, depending upon various empirical conditions, it might turn out that the best way to insure that the basic structure satisfies the difference principle is to establish a state-enforced right to health care. But whether maximizing the prospects of the worst-off will require such a right and what the content of the right will be will depend upon what weights are to be assigned to health care and to other primary goods included under the difference principle. Similarly, a weighting must also be assigned if we are to determine whether the share of wealth one receives under the difference principle would be sufficient both for health care needs and for other ends. Unfortunately, though Rawls acknowledges that a weighted index of primary goods is needed if we are to be able to determine what would maximize the prospects of the worst-off, he offers no account of how the weighting is to be achieved.

The problem is especially acute in the case of health care, because some forms of health care are so costly that an unrestrained commitment to them would undercut any serious commitment to providing other important goods. Thus, it appears that until we have some solution to the weighting problem, Rawls's theory can shed only a limited light upon the question of priority-relations between health care and other goods and among various forms of health care. Rawls's conception of primary goods may explain what distinguishes health care from goods that are not primary goods, but this is clearly not sufficient.

Perhaps because he is aware of the exorbitant demands that certain health care needs may place upon social resources, Rawls stipulates that the parties in the original position (choice-situation) are to choose principles of justice on the assumption that their needs fall within the "normal range." His idea may be that the satisfaction of extremely costly special needs for health care may not be a matter of justice but rather of charity. Here it seems that Rawls is appealing tacitly to something close to the notion of a decent minimum of health care, where the minimum is assumed to be whatever is adequate for individuals whose needs fall in the normal range. The further assumption may be that the share of resources guaranteed to each individual through the operation of the difference principle will suffice to provide the minimum.

However, Rawls does not tell us how we are to determine the normal range of needs. And even if the normal range of needs were specified, it would still be necessary to supply an

argument showing that justice requires individuals to be provided with resources to satisfy these needs, but not those that fall outside the normal range. If some reasoned way could be developed to draw a line between "normal" needs, which fall within the ambit of principles of justice, and "special" needs, which are the proper object of the virtue of charity, then this would be a step toward solving the priority problems mentioned above.

It has been suggested that the parties in Rawls's original position (choice-situation) might, because they recognize the important influence of health on life-prospects, choose a separate principle specifying a right to health care.¹⁰ However, since social resources are scarce and since the parties would recognize the importance of primary goods other than health, this principle will not be one establishing a strong equal-access right. But if this is so, then this proposal faces the same weighting problem encountered earlier. Until we know how we are to weight health care against other important social goods we have no way of specifying the content of a Rawlsian right to health care.

Rawls specifies that to ensure impartiality and unanimity, the parties to the ideal contract are to choose principles of justice from behind a "veil of ignorance": no one is to know his or her class position, race, ethnicity, or even gender. It is important to see that the stringent informational constraints imposed by the veil of ignorance preclude a solution to the problem of weighting health care against other primary goods or of determining the normal range of needs for which resources are to be provided; in both instances the answer will depend upon facts about particular conditions of the society in which the notions in question are to be applied. It appears, then, that at best Rawls's hypothetical contractors would choose a kind of "placeholder" for a principle establishing a right to a decent minimum of health care, on the assumption that the content of the right can only be filled out at later stages of agreement in the light of specific information about their particular society.

However, nothing in Rawls's conception of rational decision suggests that once the relevant, concrete information is available, rational persons will agree on a single assignment of weights to the primary goods—or that they will agree that only a certain range of normal health needs are relevant to questions of justice. It follows that Rawls's theory does not itself supply content for the notion of a right to a decent minimum of health care: Instead, at best it lays down a very abstract structure

¹⁰ Ronald M. Green, *Health Care and Justice in Contract Theory Perspective*, in *ETHICS AND HEALTH POLICY*, edited by Robert M. Veatch and Roy Branson, Ballinger Publishing Co., Cambridge, Massachusetts, 1976, pp. 111-126.

within which this content will be determined through the democratic political processes specified by the list of equal basic liberties. If this is so, then Rawls's theory advances us very little beyond the broad intuitive consensus that there is a universal right to a decent minimum of health care.

Equal Opportunity Argument (Daniels). Partly in response to some of the difficulties noted in the previous section, Norman Daniels has developed an alternative Rawlsian approach to the right to health care. Instead of basing the right to health care on an intuitive but ill-defined notion of a decent minimum or deriving the right from the difference principle or a distinct Rawlsian principle allocating health care resources, Daniels proposes that a universal right to health care is founded ultimately on a stronger, more inclusive version of Rawls's principle of fair equality of opportunity. As we shall see shortly, there are difficulties in understanding just what Daniels's principle of equal opportunity is, but we can begin by sketching two leading ideas of his view.

First, Daniels introduces the idea of "the normal opportunity range" for a given society. This is "the array of life-plans reasonable to pursue within given conditions obtaining in a society."¹¹ Daniels's second point is that we can best understand the distinctive nature and importance of health care if we see that it promotes, restores, or provides surrogates for "normal species functioning," and that normal species functioning is an important contributor to an individual's attainment of the normal opportunity range for his society.¹² The principle from which health care rights are derived according to Daniels may be stated as follows.

(D). Social resources are to be allocated so as to insure that everyone can attain the normal opportunity range for his or her society.

The success of Daniels's approach depends upon the plausibility of the over-arching principle (D) of equality of opportunity; it also depends on the plausibility of the implications of this principle for health care entitlements. Though he has not yet committed himself unequivocally on this issue, it seems that Daniels believes that principle (D) implies a right to health care that exceeds what is usually thought of as a right to a decent minimum. What is certain is that he believes his approach avoids the obscurity of an undefined notion of decent minimum and the arbitrariness of Enthoven's strategy of simply specifying a list of services based on current standards for third-party payment arrangements. Daniels emphasizes that the

¹¹ Norman Daniels, *Health Care Needs and Distributive Justice*, *PHILOSOPHY & PUBLIC AFFAIRS*, Vol. 10, no. 2 (Spring 1981), pp. 146-179.

¹² *Ibid.*

connection between normal species functioning and opportunity and the idea that health care is whatever promotes, restores, or replaces normal species functioning achieves two important goals of a theory of health care: It gives us a way of ranking the importance of various health care services for normal species functioning, and it provides a principled way of defining the class of health-care needs—one that does not limit them to medical needs, as does the current health care delivery system.

A natural objection to Daniels's view is that even if one reason health care is important is that it contributes significantly to attainment of the normal opportunity range, this is surely not the only reason, nor in many cases the most basic one. After all, health care often relieves suffering, prevents unwanted death, or enhances one's capacity for enjoying whatever one is able to do, even when it does not extend one's range of opportunities. Though I think this criticism has considerable force, I believe there are other, more telling objections.

The first difficulty is the definition of "normal opportunity range." The phrase "the array of life-plans reasonable to pursue" is ambiguous. For whom must a life-plan be reasonable to pursue if it is to be included in the normal opportunity range? If to be included a plan must be reasonable for everyone to pursue, regardless of individual physical abilities, skills, and talents, then the list will be so modest that it is doubtful it could provide content for a substantive universal right to health care of the sort Daniels wants. If, on the other hand, inclusion in the normal opportunity range requires only that the plan be reasonable for someone or other to pursue it, then principle (D) becomes astonishingly strong, since it will include life-plans requiring exceptional talents and rare characteristics.

Using this strong interpretation, Daniels's principle of equality of opportunity would be vulnerable to the same objection that leads to rejection of the strong equal-access principle. Granted the gap between most individuals' actual opportunity ranges and the array of plans it is reasonable for some individuals to pursue, and granted the almost limitless possibility for technology and other services that can help narrow the gap, it seems that a conscientious commitment to principle (D) would create an enormous drain on resources. It seems excessive, to say the least, to hold that everyone has a right to whatever arrangements insure that it is reasonable for him or her to aspire to become a neurosurgeon, a first-class logician, an accomplished pianist, or the spouse of a movie star.

It is important to see that this objection cannot be met by replying that the right to health care is only a right to the resources required to promote, restore, or provide surrogates for normal species functioning. For even if it could be shown that this goal is much more modest than that of achieving the nor-

mal opportunity range (in the strong interpretation) for all, this would be beside the point. In Daniels's view the basic consideration is the attainment of equality with respect to the normal opportunity range, normal species functioning is only important as one factor among others that contribute to it. So my objection is to the basic principle of justice Daniels proposes. This is not to deny, however, that a commitment to achieving the equivalent of normal species functioning for all—even those with multiple, severe disabilities—would not also be implausibly demanding as a requirement of justice, rather than of generosity or charity.

Finally, if neither the strong nor the weak interpretation is acceptable, Daniels might suggest that the normal opportunity range is that array of life-plans constituting a normal or tolerable or adequate or decent life in the society in question. This strategy, however, is one that Daniels should be reluctant to embrace, since he introduced the notion of a normal opportunity range in the first place to avoid the unilluminating move of specifying the notion of a decent minimum by reference to equally uninformative notions such as that of an adequate or tolerable life.

A second difficulty is that if we eschew the strong interpretation, the attempt to derive a right to health care from the right to enjoy the normal opportunity range for one's own society may involve a sort of circularity that has unfortunately conservative implications for health care policy. The array of life-plans that all (or most or many) people in a given society can reasonably pursue, or that constitute a tolerable or normal or adequate life in that society, will be determined in part by the availability and quality of health care in that society. In other words, the normal opportunity range is itself in part a social artifact. Thus in a society with very poor health services the normal opportunity range would be correspondingly narrow, even if the society were affluent enough to afford a wider range of services (which would allow a wider normal opportunity range). Consequently, a principle requiring only that resource allocation assure that everyone attains the normal opportunity range would be inadequate in situations in which the normal opportunity range is unacceptably narrow due to a failure to allocate sufficient resources for health care. This suggests that Daniels's principle requiring equal opportunity must be supplemented with a principle requiring maximization of the opportunity range, or at least that the opportunity range is maximized to some limit. After all, the importance of health care in Daniels's account is that it facilitates opportunity; and anyone who is concerned with opportunity rather than with equality for its own sake will desire arrangements that require more than mere equal opportunity where opportunities are few but can be expanded.

It is worth emphasizing that a principle requiring equality of opportunity in a given opportunity range and a principle requiring maximization of the opportunity range (or maximization to some limit) may conflict with one another. But if this is so and if both principles must be given some weight in a reasonable theory that recognizes opportunity as a fundamental value, then some way of balancing the demands of these two principles must be found. In a society with no legal barriers to opportunity and none based on racial or sexual discrimination, it is not obvious that either justice or rational self-interest would require (as Daniels seems to assume) the choice of a system that guarantees the same opportunity range for all rather than a system that allows some inequalities but a wider opportunity range. If the latter alternative is appropriate, then we are again pushed in the direction of the vague but intuitively plausible notion of a decent minimum—this time the notion of a decent minimum opportunity range to which the requirement of equality applies.

For a theory that makes both the maximization of the opportunity range and equality in the opportunity range matters of justice, the problem of weighting these two conflicting principles is itself a basic problem of distributive justice—if the level at which the normal opportunity range is set is itself in part a matter of social choice. If the scope of the normal opportunity range is subject to our control, we must decide whether to set a rather narrow opportunity range so that even the worst-off may attain it or to allow a wider opportunity range that may be attainable by the average person, or by above-average persons, but not by the impaired. To answer this question additional principles of distributive justice are needed. The lack of any such principles is a much more basic and systematic defect in Daniels's approach than the problem, faced by all theories of distributive justice in health care, of what proportion of resources we are to allocate for those severely impaired individuals who will benefit very little even from the most expensive care.

A third and somewhat surprising feature of Daniels's position, and one which many will view as objectionable, is that it appears that principle (D) does not guarantee a universal right to a decent minimum of health care. Notice that principle (D) is silent on how we are to make difficult and basic allocation decisions. It does not tell us whether we are to devote all resources to narrowing the distance between the opportunity ranges of the worst-off and the normal opportunity range or if we are to divide resources among all who fall short of the normal opportunity range. Indeed nothing in principle (D) even acknowledges that there is a problem of scarcity. (In this respect principle (D), like the socialist slogan "To each according to his need," looks more like a principle describing distribution that would be possible if there were no problem of scarcity than a

prescriptive principle of distributive justice designed to cope with the problem of scarcity).¹³

Whether or not principle (D) will require some minimal set of health care services for all will depend upon which additional principles we adopt to cope with priority problems in the face of scarcity. If our first priority is to narrow the gap between the worst-off and those in the normal opportunity range, then, depending on how badly off the worst-off are and depending upon the total amount of resources available, there may be nothing left for even minimal services for those who do not fall within the worst-off class. As in the case of utilitarianism, whether there is a universal right to a decent minimum will depend upon the facts about the society in question. But in Daniels's scheme it will also depend upon what additional principles of distributive justice are used to supplement the principle of equality of opportunity when the commitment to such a strong principle collides with the realities of scarcity.

If, on the other hand, the commitment to raising the opportunity range of the worst-off is to be limited by a principle stating that everyone has a right to some set of services even if there are others who are farther from the normal opportunity range, then unless this universal right-claim can be non-arbitrarily specified and supported, it appears that we have again ushered in the idea of a decent minimum. And contrary to what Daniels says, his principle of equality of opportunity is a supplement, rather than a replacement for this idea.

We may conclude that Daniels's emphasis on equality of opportunity and on the contribution to opportunity of normal species functioning facilitates the ranking of various forms of health care and also shows why many non-medical services should be included in a right to health care (if there is such a right); however, it does not provide a plausible theory of distributive justice in health care that avoids the vagueness of the popular notion of a right to a decent minimum. Instead, Daniels' principle of equal opportunity raises at least as many problems of distributive justice as it answers, requires supplementation by other principles of distributive justice, and, in its more plausible interpretations, seems to appeal covertly to the very notion of a decent minimum it was designed to avoid.

Enforced Beneficence Argument. So far we have considered several proposed principles of justice and have seen, rather surprisingly, that they either do not provide a firm basis for the claim of a universal right to a decent minimum or else that they encounter serious difficulties in supplying a practical specifi-

¹³ Allen Buchanan, *MARX AND JUSTICE: THE RADICAL CRITIQUE OF LIBERALISM*. Rowman and Littlefield, Totowa, New Jersey, 1982, pp. 50-86.

cation of the content of that right. These deflationary results would be welcomed by a libertarian, who would explain them by the hypothesis that *there is no right to a decent minimum*. Further, a sophisticated libertarian would explain the pervasiveness of the (false) belief that there is a right to a decent minimum by hypothesizing that those who hold this belief have mistaken the moral imperatives of beneficence or charity for those of justice.¹⁴

It can be argued, however, that even if the libertarian were right thus far, there is still a sound justification for an enforced principle guaranteeing a decent minimum of health care to everyone. The possibility of delineating such an argument depends upon the assumption that some principles may be coercively sanctioned even if they do not specify valid right-claims. There are at least two widely recognized classes of such principles: certain rules of social coordination (e.g., the rule of the road, "Drive only on the right") and principles requiring contribution to the production of certain "public goods" in the technical sense (e.g., tax laws requiring contribution to national defense). In both types of cases there may be no *right* that is the correlative of the coercively-backed obligation specified by the principle.

Since the second class includes redistributive principles—ones that impose an obligation to contribute resources for the benefit of others—it seems most plausible to explore the possibility that this second class of principles may provide the key to an argument for a non-rights-based enforceable principle requiring a decent minimum for all, since such a principle would also be redistributive. We shall see, however, that the most plausible argument will depend upon both the idea of coordination and certain aspects of the concept of a public good.

The argument begins with an assumption that reasonable libertarians accept: There is a basic moral obligation of charity or beneficence to those in need. In a society that has the resources and technical knowledge to improve health or at least to ameliorate important health defects, the application of this requirement of beneficence includes the provision of resources for at least certain forms of health care. If we are sincere we will be concerned with the efficacy of our charitable or beneficent impulses. It is all well and good for the libertarian to say the voluntary giving can replace the existing array of government entitlement programs, but this possibility will be cold comfort to the needy if, for any of several reasons, voluntary giving falters.

¹⁴ On this point Robert Nozick's views may be taken as representative of the libertarian position. See *ANARCHY, STATE AND UTOPIA*, Basic Books, New York, 1974.

Social critics on the left often argue that in a highly competitive, acquisitive society such as ours it is naive to think that the sense of beneficence will win out over the urgent promptings of self-interest. But one need not argue that voluntary giving will fail from weakness of the will. Instead one can argue that even if each individual recognizes a moral duty to contribute to the aid of others and is motivationally capable of acting on that duty, some important forms of beneficence will not be forthcoming because each individual will rationally conclude that he should not contribute.

Many important forms of health care, especially those involving large-scale capital investment for technology, cannot be provided except through the contributions of large numbers of persons. This is also true of the most important forms of medical research. But if so, then the beneficent individual acting alone will not be able to act effectively. What is needed is a coordinated collective effort.

Suppose, for example, that prompted by my sense of beneficence I wish to alleviate the suffering of those with arthritis. Suppose also that I have reason to believe that the most effective way of aiding those with this affliction is to institute a combination of treatment and research programs on a scale vastly beyond my assets. No matter how strong my sense of beneficence is, I will conclude that it would be less than rational—and even morally irresponsible—to contribute my resources to such programs unless I can be assured that enough others will contribute to achieve the capital investment needed for success. For unless I am so assured, the rational thing for me to do is to use my resources in some other expression of beneficence that does not depend for its success upon the contributions of others. I might conclude, for example, that it is better to buy aspirin for two or three local arthritics, even though I know that the dollars I spend in this way—if combined with similar contributions from others—could do much more good if employed in large-scale research and treatment programs. But if everyone (or a sufficient number of other beneficent persons) reasons in this way, the result will be a relatively ineffective patchwork of small-scale charitable efforts rather than the coordinated collective effort that is most effective.

Notice that this problem in no way depends upon an assumption of conflict between the individual's moral motivation of beneficence and his inclination of self-interest. Instead the difficulty is that in some important cases individuals who strive to make their beneficence effective will thereby fail to benefit the needy as much as they might. What is interesting about this situation is that individual rationality erects a barrier to successful collective action even in the absence of the crucial feature of a public good. A necessary condition of something being a public good (in the technical sense) is that it is either

impossible or excessively costly to exclude non-contributors from partaking of the good—if it is produced. But in the case at hand this condition is not fulfilled, since an individual will not achieve the good of acting most effectively so as to discharge his obligation of beneficence unless he does contribute. Yet individual rationality results in a failure of collective action nonetheless, because even where the non-excludability requirement is unsatisfied a rational beneficent individual will not contribute if he lacks assurance that enough others will do so.

A standard response to those “paradoxes of rationality” known as public goods problems is to introduce a coercive mechanism that attaches penalties to non-contribution; this provides each individual with both the assurance that enough others will reciprocate so that his contribution will not be wasted and an effective incentive for him to contribute even if he has reason to believe that enough others will contribute to achieve the goal without his contribution.

I suggest that even if they rightly believed that the needy have no right to health care, rationally beneficent individuals would agree to establish a coercively-backed principle specifying certain health programs for the needy and requiring those who possess the needed resources to contribute to such programs. Such an arrangement would serve a dual function: It would coordinate charitable efforts by focusing them on one set of services among the indefinitely large constellation of possible expressions of beneficence, and it would assure that the decision to allocate resources to these services will become effective.

It might be objected that this argument rests upon either of two unacceptable premises: (1) that if something is a moral principle (or at least a basic moral principle), then it may be given the status of a law and enforced by the state; or (2) that it is the state’s role to insure that its citizens are morally virtuous. If the “enforced beneficence” argument rested on either of these very general premises it would be implausible, because both premises have unacceptable implications for individual liberty. But the enforced beneficence argument does not assume that any moral principle (or any basic moral principle) may be enforced; nor does it assume that the state is the guardian of our morals. Instead, it only contends that one important moral principle may be enforced if, in the absence of enforcement, lack of coordination and lack of assurance of the contributions of others would make it rational for us not to act on the principle. Further, it seems most plausible to regard the conclusion of the enforced beneficence argument as defeasible: If political conditions were such that the establishment of the required enforcement mechanism would contribute to a dangerous concentration of government power, then the lesser of evils might be to forego a solution to the coordination and assurance problems.

However, it is unpersuasive to argue that—at least in the United States at this time—the establishment of a compulsory contribution scheme would constitute an unacceptable threat to liberty by endowing the government with uncontrollable powers. Moreover, some of the most significant dangers that make a general policy of the “enforcement of morals” unacceptable simply do not apply with any force to this case. In particular, opponents of the enforcement of morals usually rightly point out that such a policy would destroy the conditions required for individual autonomy, privacy, and the flourishing of intimate personal relationships. This is certainly true for the enforcement of many moral principles, especially principles of sexual or religious morality; but it is not all convincing in arrangements to enforce the moral duty of charity or beneficence. Nor is it obvious that enforced beneficence should be rejected because it will inevitably lead to the enforcement of those moral principles more closely connected with autonomy, privacy, and intimate personal relationships. If the argument I have only sketched here can be adequately developed, the weaknesses of the various rights-based arguments considered earlier will not be fatal to the claim that everyone ought to be guaranteed a decent minimum of health care, even if this requires coercive governmental action.

Before attempting a brief summary of our lengthy exploration of the notion of a right to a decent minimum, I would like to observe that the non-rights-based enforced beneficence approach has surprising implications for the issue of how to specify the content of the decent minimum. We have seen that, while the type of rights-based argument determines the sorts of considerations that are to guide the specification of content, little can be said about specification prior to the outcome of political processes or extensive empirical research. This conclusion will be disturbing if one assumes that the guaranteed minimum is a right, since we often think of rights as rather sharply defined. However, the traditional notion of duties of charity or beneficence is that they are “imperfect duties”: By their very nature they are not precisely delineated. In the case of individual charitable activity a person has discretion to decide not only how much to give, but even to whom to give it.

Now those who favor the non-rights-based approach can argue that the difficulty encountered by rights-based approaches in specifying the content of an alleged right to a decent minimum provides indirect support for the position that there is no right to a decent minimum, but only an enforceable duty of beneficence or charity to contribute to the attainment of a decent minimum. In other words, the advocate of the enforced beneficence approach can warmly welcome the lack of a principled specification as a vindication of his view rather than accept it begrudgingly as an embarrassing theoretical lacuna. The idea would be that we must frankly acknowledge that the

character and scope of the list of services included in the decent minimum are matters of choice, just as the character and scope of an individual's charitable activity are. All that is necessary is some fair procedure for reaching a social decision on which set of services to provide.

The matter is not quite so simple, however. Even if the requirements of beneficence cannot be precisely specified, the same traditional view that distinguishes between charity or beneficence and justice also acknowledges that there are limits. Once these limits are passed, charity or beneficence becomes supererogation, or perhaps perfect generosity; and even if the notion is plausible that some requirements of charity (or beneficence) may be enforced, the idea of enforced supererogation may not be plausible. Consequently, if the non-rights-based approach is to be acceptable, it may be necessary to select a range of contribution levels that falls between the minimal requirements of charity (or beneficence) and the threshold of supererogation.

Conclusion

The results of the investigation may now be briefly summarized. Though there is a broad consensus both in the philosophical literature and in policymaking circles that a right to a decent minimum of health care exists, there is much disagreement about the content of the alleged right. Further, both the claim of a right to a decent minimum and the specification of its content must be given a foundation in moral theory—it does not suffice to appeal to existing institutional entitlements and the expectations they generate.

However, the pervasive belief that any of several major theories or principles of justice can provide an adequate justification for such a right is not well supported. Contrary to the argument of those who tend to group the right to a decent minimum of health care with the right to a basic education, the notion that health care is required for the effective exercise of other basic rights cannot by itself provide a sound justification for a substantive universal right to a decent minimum of health care—though it may ground some rights to services of various kinds, including some health services, for some persons.

While utilitarianism may require some health care rights, it does not provide a firm foundation for a universal right to a decent minimum. This is because maximizing utility may require the exclusion from even minimal services of some groups of persons who are severely disabled and therefore incapable of making a sufficient contribution to the good of others, even if these individuals would benefit greatly from the services. Arguments that purport to show either that utilitarianism would give special stipends to all disabled groups or to none are

unwarranted generalizations. Whether any particular group of the disabled would receive a special set of services or none at all depends upon a number of empirical factors.

Rawls's hypothetical contract theory may provide both a justification for a right to a decent minimum and, through the conception of primary goods, a way of explaining what makes health care especially important. However, in the absence of a procedure for weighting health care against other primary goods, Rawls's contractarian approach yields only a contentless "place-holder" decent minimum principle whose content can only be filled in by democratic political processes in which the informational constraints of the original position are relaxed.

Norman Daniels's revision of the Rawlsian approach provides a plausible account of at least one important characteristic of health care: Health care contributes to normal species functioning, which is one basic determinant of the opportunity range open to an individual. This allows us to rank the importance of various health services and to give a principled account of why health services include, but are not limited to, medical services. However, the principle of equality of opportunity advocated by Daniels is subject to a serious ambiguity: A strong interpretation of it makes excessive demands on resources and is as implausible as the strong equal-access principle; a weaker interpretation seems to rely tacitly upon the vague notion of a decent minimum it was designed to replace. Finally, granted that the normal opportunity range for a society is itself partly a matter of social choice, the commitment to maximizing the opportunity range attainable by most people or most "normal" people conflicts with the commitment to achieving equal opportunity; yet Daniels provides no way of resolving such a conflict. More generally, Daniels's approach is silent on the basic questions of distributive justice that his principle of equal opportunity forces upon us: Ought we to direct our efforts to improving the condition of those farthest from the normal opportunity range? Or ought we to do so only to some limit and then allocate resources to expand the normal opportunity range or improve the condition of those who are closer to attaining it than the worst-off? Since Daniels's principle of equal opportunity is not supplemented by principles for resolving such conflicts, it is more appropriate to refer to his view as a part of a theory of distributive justice in health care.

Finally, we explored briefly an argument for an enforceable decent minimum based not on a principle of justice but upon the requirements of collective efforts for the fulfillment of moral obligations of charity or beneficence. It was seen that such an argument is not vulnerable to standard objections to the enforcement of morals. When the enforced beneficence argument is combined with familiar prudential arguments, including arguments for traditional public health measures, and

with the earlier arguments for *special* moral rights to health care, the result is a compelling case for creating an extensive set of legal entitlements to health care, even in the absence of a universal moral right to health care.

Distribution of Health Care And Individual Liberty

J

Dan W. Brock, Ph.D.*

Two distinct concerns surface in much current discussion of the health care system, and more specifically in various proposals for restructuring that system. The first is whether unjustified inequalities persist in access to and in utilization of the health care system by various groups, and if so how those inequalities might be removed. The second concern is the steadily and rapidly increasing cost of health care, and how such cost increases can be controlled. Many current proposals for restructuring the health care system can be seen as primarily directed to one or both of these quite different goals—reducing inequalities in access to health care and containing costs. In the first section of this paper I shall spell out in a bit more detail three aspects of the access problem, and say something more about the policy goal of cost containment. Unequal access to health care is a moral problem only if it is assumed that persons have some moral claim (or, as it is often put, a moral right) to health care, and I shall also make that assumption explicit in the first section.

Next, I shall distinguish two paradigmatic approaches to realizing equity of access to health care and cost containment. The first approach seeks to introduce more competition into the health care system, to make health care markets more competitive. This market approach often takes the form of a voucher system designed to preserve and enhance a free market in health care, while also guaranteeing universal access to health care. I shall use Alain Enthoven's Consumer Choice Health Plan as an example of this approach.¹ The other paradigmatic ap-

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¹ Alain Enthoven, *HEALTH PLAN: THE ONLY PRACTICAL SOLUTION TO THE SOARING COST OF MEDICAL CARE* (Reading, Mass.: Addison-Wesley Publishing Company, 1980).

proach in effect gives up on markets for improving access and achieving cost containment, and turns instead to government action to provide the needed changes. There are obviously many possible kinds and degrees of government intervention. The extreme position here is usually some form of national health care service under which the government is directly responsible for the financing and provision of health care services. More modest approaches usually involve universal health insurance together with substantial government regulation to correct for various market malfunctions or market inability to satisfy other desiderata of the health care system.

It is largely the task of social scientists, and most especially of economists, to predict the consequences for distribution and cost containment of health care that would result from adoption of either of these two approaches. But there is often one specifically moral issue raised in the evaluation of such restructuring proposals that will be the focus of my concern in the third section. It is often argued that the important value of individual liberty, a moral right to liberty or autonomy, provides important constraints on the manner and extent to which the two goals of greater equality in health care and cost containment can be pursued.² Alternatively, it is argued that liberty provides a significant moral basis for preferring the market approach to realizing these goals. The constraints imposed by liberty—either for patients, physicians, or the medical profession—on attempts to improve equality of access and to institute cost containment are the focus of this paper.

Distributional Issues Affecting Equal Access

It will be helpful to distinguish three distinct distributional issues within the health care system affecting equity of access to health care.

Income. Virtually all relevant empirical studies show that there have been substantial gains in improving access to health care for the poor over the last 15 years, though most studies also indicate that some gap still remains. The poor continue to have worse health status than the nonpoor, and so a utilization measure of health care must at least adjust for such differences if it is to measure whether those with similar health care needs have

² The concepts of liberty and autonomy are not identical, though for my purposes in this paper they are usually interchangeable. I generally refer to individual liberty, except in a few instances where autonomy is the more natural concept. Nothing substantive here turns on which of the two words is employed.

similar utilization patterns.³ While without adjustment for health status physician visits for the poor now slightly exceed those of higher-income people, when adjustments are made for health status the poor use fewer physician services than those of higher income.⁴ Also, if we consider a plausible measure of potential access (as opposed to actual utilization), more low-income than high-income persons have no particular physician or other regular care source.⁵ In particular areas of care such as preventive care—including prenatal exams, pap smears, breast exams, and childhood immunizations—as well as dental care, the poor are much less likely to receive care than the nonpoor. The poor are also much less likely to have any or adequate insurance coverage. In general, significant inequalities remain, disfavoring the poor in access and utilization of health care relative to their health care needs.

Location. The Department of Health and Human Services (DHHS) estimates that about 52 million Americans live in medically underserved areas, largely inner-city and isolated rural areas; about 20 million of these persons are considered to be a high-priority underserved population. Studies also show that availability of medical services and physical access to care are still important determinants of medical care utilization—even when financial access is assured.⁶ A number of programs in the last decade have been targeted at remedying the maldistribution of physicians. They have included education loans to medical students with forgiveness conditions for practice in underserved areas, rural preceptorships for medical students, efforts to increase the total number of physicians, the National Health Service Corps (operating in largely rural areas), and Community Health Centers (aimed at both rural and inner-city areas).⁷ Many

³ John Yergan, et al, *Health Status as a Measure of Need For Medical Care: A Critique*, Appendix S in Volume Three of this Report, Karen Davis, Marsha Gold, and Diane Makuc, *Access to Health Care for the Poor: Does the Gap Remain?* ANNUAL REVIEW OF PUBLIC HEALTH, Vol. 2 (1981), p. 159.

⁴ J.C. Kleinman, *NHIS Results by Income and Insurance* (Hyattsville, MD: National Center for Health Statistics, 1980); J. Modans and J.C. Kleinman, *Utilization of Ambulatory Medical and Dental Services among the Poor and Nonpoor* (Hyattsville, MD: National Center for Health Statistics, 1980); L.A. Aday, R. Andersen, and G.V. Fleming, *HEALTH CARE IN THE U.S.: EQUITABLE FOR WHOM?* (Beverly Hills, CA: Sage Publications, 1980); Davis, et al., op. cit.

⁵ Davis, et al., p. 21.

⁶ *Ibid.*, pp. 34, 37.

⁷ A useful survey and assessment of programs to remove various inequalities in access to health care can be found in Charles Lewis, David Mechanic, and Rashi Fein, *A RIGHT TO HEALTH: THE PROBLEM OF ACCESS TO PRIMARY MEDICAL CARE* (New York: John Wiley & Sons, 1976).

persons, however, remain uncovered or inadequately covered by such target programs. The reasons for the limited impact of these programs on geographical distribution are complex and varied, and include the important factors of inadequate political support coupled with inadequate funding. But relevant as well to the issues to be discussed below is that all of the programs cited above made physician participation in the programs voluntary, depending on market and other incentives to gain participation.

Maldistribution of Specialists. This distributional problem is included here because of its impact on both inequalities of access and cost escalation. Two examples will serve to illustrate the linkages. It is generally conceded that the U.S. has an oversupply of general surgeons, and that a strong case can be made that the oversupply of surgeons is implicated in the high rates of unnecessary surgery. In general, unnecessary medical treatment that is in part generated by an oversupply of medical specialists contributes to the overall escalation of medical costs, and in turn to the pressures for cost containment. On the other hand, between 1930 and the early 1970s the proportion of physicians engaged in primary care, which is the principal point of initial access to the health care system, declined by over 50%, while the population per primary care physician more than doubled; both these trends were reversed in the latter half of the 1970s. Just as the oversupply of surgeons leads to an overutilization of surgical procedures, an undersupply of primary care practitioners probably leads to underutilization of some health services, and to less effective, less comprehensive care for many persons. Oversupplies and undersupplies of physician specialists contribute to a general reduction in the matching of appropriate medical care to medical needs. Both increasing the total number of physicians, as well as supporting family practice as the primary care specialty have been aimed at improving the distribution by specialty; while the latter especially has increased the proportion of primary care practitioners, the problem of maldistribution remains. Both approaches again rely largely on the voluntary choices of medical students within the present organizational structure of medical training and practice.

At the present time, efforts to control increases in health care costs probably have at least as high, if not a higher, place on the public policy agenda as does improving equity of access. There are two significantly different sources of the pressure to contain health care costs. One concern is with the rate of increases in and level of total health care expenditures. Total expenditures for health care over the last decade have risen faster than overall growth in the economy, and now consume over 9% of the Gross National Product. Hospital costs have been a particularly rapidly rising component of such expenditures. A number of programs instituted in the last decade, including

state Health Planning and Development agencies and local Health Systems Agencies, Professional Standards Review Organizations, Health Maintenance Organizations (HMOs), have had cost control as one of their aims. A different source of pressure for cost containment derives from political pressures to reduce the role of government in the health care system generally, and to reduce government outlays for public health care programs in particular. Among direct Federal health care expenditures, both Medicare and Medicaid are slated for significant cuts in fiscal 1983.

It is by no means obvious that either public or total health care expenditures truly are excessive, nor is it even clear how that might be shown. I intend no endorsement here of any particular cost-containment programs, but simply note that it is reasonable to expect that cost containment in one form or another will be an important policy objective—perhaps the major policy aim in restructuring proposals for the health care system that are developed over the next several years. Each of the polar reform proposals that I shall sketch in the next section seeks to contain total health care costs and to improve access. One is clearly aimed at reducing Federal health care expenditures. While cost containment is a policy aim distinct from the goal of improving equity in access to health care, it will clearly be a major determinant of reform proposals, and will in turn help determine the liberty issues those proposals raise. To the extent that cost containment is aimed at the public sector, it creates the prospect of an erosion of the gains of the last years in access to health care for the poor, who are disproportionately served by that sector. The goal of cost containment is potentially in sharp conflict with improving equity of access.

Before lack of access to health care will be perceived as a moral problem, in turn generating restructuring proposals of the sort to be sketched in the next section, it must be seen as violating some person's legitimate moral claims. Our society tolerates many inequalities, including substantial inequalities in income and the many goods and services that it secures. In contrast to this, it is commonly (though, of course, not universally) agreed that similar inequalities in access to health care—and in particular a lack of access to even some basic minimum of health care—is an injustice to those denied access. Health care is commonly classed with other basic needs such as food, shelter, and education—all goods to which most agree all persons have a moral claim or right. Justifying the position that persons are morally entitled to health care would require fitting health care appropriately within a general theory of distributive justice or moral rights. This would involve accounting for the special priority or importance that health care is thought to have, and then relating this importance to conditions that (in a particular theory of justice) generate moral entitlements or rights. This is a complex matter for at least two reasons. First,

there are several alternative explanations of the special importance of health care; for example, health care may be considered important because of its effect on one's opportunities, or because of its role in preventing and alleviating pain and suffering and in prolonging life, or because of its effect on one's capacity to exercise other rights and liberties, or because of the great inequality and uncertainty of people's needs for it. Second, radically different general theories of distributive justice incorporate the distribution of health care in substantially different ways. Such issues are central for a theory of justice in health care, but this paper is not the place to explore them. Here, I shall simply assume but not argue that there is a claim of justice, which can be framed as a moral right, to at least some basic minimum of health care. I believe that such a right is implied by most theories of distributive justice. Moreover, I believe it is only if some such assumption is accepted that restructuring proposals of the sort sketched in the next section are seen to take on moral urgency, and then to raise doubts about physician or patient liberties.

Two Models

Two of the three aspects of the inequitable access problem, as well as the problem of health care cost escalation, can be interpreted as (at least in significant part) instances of market failure. Inequalities in access associated with income inequalities are not a result of failure of health care markets to the extent that the poor lack access because they lack the purchasing power to turn their medical needs into effective demand in the health care marketplace. If it is accepted that poverty should not be a barrier to satisfying at least a certain level of health care needs, then the market proponent can favor insuring that the poor have whatever is the appropriate level of purchasing power, which they can then use to enter the medical marketplace. If the poor have insufficient purchasing power for the health care that ought to be available to them, that is a failure of income redistribution mechanisms in the society, not of health care markets. The other problem areas more clearly involve health care market failures.

Inequalities in access associated with geographical location largely represent supply failures, failures of sufficient numbers of physicians and other health care personnel to locate in medically underserved areas. The most common economic explanation offered for this market malfunction is that physicians influence the demand for their services, allowing them to locate in areas already well-supplied with physicians, where they can then generate new demand for their services.

The maldistribution of medical specialists is also commonly explained by the relative immunity of physicians to market forces. To the extent physicians can create their own

demand, they need take less account of patient needs and the oversupply or undersupply of physicians in different specialties in making their specialization decisions. If surgery has attractions such as high incomes and shorter work hours, even though there may be too many surgeons, new surgeons can generate demand for their services while maintaining high surgical fees. The result is that the market has only limited impact in redistributing the supply of physicians in accordance with the needs of patients.

The most obvious market failure generating a lack of cost control, and so a need for cost containment, arises from the widespread use of third-party insurance payment for health services. This removes the necessity for the health care consumer, the patient, to take account of the true costs of health care services in his decision to utilize them. Once he has insurance, he will bear at most only a small fraction of the cost of a service purchased; this leads to an overutilization of services when benefits are weighed against true costs. Moreover, most observers of the health care system agree that decisions to order services are largely in the hands of physicians, not patients. Physicians who order services do not pay for them, but instead financially benefit from them. Consequently, they have only limited incentives to weigh costs and benefits in their decisions.

Consumer Choice Health Plan. All of the above are, of course, enormously oversimplified accounts of the economic causes of these problems; and there are certainly other causes. I have wanted to suggest as briefly as possible why it might be thought that these problems were principally a result of failures and imperfections in health care markets, and so in turn to suggest why it has seemed plausible to many that the way to deal with such problems is to reduce these imperfections and to make health care markets more competitive. Alain Enthoven's Consumer Choice Health Plan (CCHP) is an example of this first broad approach to realizing equity in access while achieving cost containment. In barest outline, CCHP is an attempt to use market incentives to control the supply, demand, quality, and cost of health care services more than present arrangements do. Under CCHP, individuals would be free to choose private health insurance or membership in any prepaid group health plan operating in their area, with different plans offering different service packages, and with rates based on total costs of all enrolled in the plan. The government's only role would be to qualify competing plans and to subsidize enrollment costs through tax credits (present tax deductions for medical costs would be eliminated), set initially at 60% of the average per capita health spending of all persons in a given region. Vouchers worth 100% of the area rate premium, which could be used only for purchase of health plans, would be issued to the poor. Enrollment in any insurance or health program would be vol-

untary, but strongly encouraged by the vouchers and the 60% tax credit.

The overall point is to introduce market incentives to economize at places where present incentives to do so are inadequate or absent, while improving equity of access. A decent level of health care would be available to all through universal subsidies of health plan memberships (in effect, a form of national health insurance), with gaps in coverage for the unemployed and others thereby filled. Health providers would have incentives to organize services efficiently and to limit costs in order to compete for enrollees. The HMO group practice favored by Enthoven offering prepaid comprehensive care instead of the present fee-for-service system contributes to the incentives for providers to limit costs. Since tax credits cover only 60% of average per capita area health expenditures, consumers would have incentives to seek efficient and less expensive plans. The incentive for consumers to seek the best buy is, of course, also designed to put pressure on providers to provide it.

I will make no attempt to evaluate the extent to which CCHP would control health care costs or remedy the three aspects of the unequal access problem noted earlier. It is plausible to suppose it would have some, though differential, effect in each of these areas. But clearly a part of the appeal of programs like CCHP is that they appear to involve minimal interference with individual liberty, with freedom of choice. Consumers remain free to choose the package of health care benefits that best fits their preferences, or indeed not to choose any if they wish, though incentives are such that few would adopt this alternative. They are also free to choose their practitioners, though under CCHP the choice would commonly be of a group of practitioners working in a particular HMO. Physicians and other health professionals would retain professional autonomy in specialization choice, organization of their practice, and financing arrangements, though they would be subject to additional competitive pressures in these areas; for example, Enthoven supposes that fee-for-service payment through third-party insurers, with its incentives for over-utilization, would be diminished or largely eliminated by competitive pressures. Likewise, physicians would remain free to decide where to practice, and what specialty to enter, hopefully again subject to stronger market incentives. The argument that could be made on the basis of individual liberty for the market approach to some of our current health care problems is an instance of the more general, traditional argument that is commonly made for free-market economic systems.⁸

⁸ A prominent example of this argument is developed in Milton Friedman, *CAPITALISM AND FREEDOM* (Chicago: University of Chicago Press, 1962).

National Health Care Service. The polar alternative approach to restructuring the health care system in effect gives up on the market and turns instead to some form of government intervention. Just as the market approaches exemplified by Enthoven's CCHP are designed to take the government out of the business of administering or regulating the health care system, so this approach puts the government more in that business. There are obviously many possible forms and degrees of an increased government role; I shall focus on one of the more extreme versions, a National Health Care Service (NHCS).⁹ A NHCS is not likely to be adopted in the near future in this country. However, if there are serious objections from patient, physician, or professional liberty to this broad approach to restructuring the health care system to achieve more equity of access while effecting cost containment, the objections should show up more clearly in this extreme form of government intervention.

Consider then a form of National Health Care Service run by the Federal government, and responsible for the delivery and financing of health care. Under the NHCS, some level of health care is made available to all persons and is financed out of general tax revenues. (I shall not attempt to specify here what that level should be, or how it should be determined.) Cost containment would be effected not by market incentives, but principally by various regulatory measures, such as area health budgeting, ceilings on annual increases in health care expenditures, protocols specifying and limiting the use of particular procedures, and so forth. I shall assume that private practitioners outside the NHCS would be permitted for those willing to pay for their services. Such private practitioners presumably would be sought because their services were thought to be of higher quality or to offer amenities not present in the NHCS, or because they offered services not available in the NHCS. The great majority of physicians under such a system, nevertheless, would likely work under the NHCS and, let us suppose, be salaried. The public-private mix would likely be very similar to that which exists in primary and secondary education. (It is possible, of course, to imagine a NHCS that prohibits private practitioners, though not now as a politically feasible policy option in this country. I shall argue that there would be serious moral objections to such a prohibition and so shall not incorporate it into my example of this non-market approach.)

The unequal access problems noted earlier are amenable to more direct action in this approach. There might be less in-

⁹ I intend this NHCS to be a purely hypothetical construct, representing an ideal type of health care system reform proposal. It is specifically not intended to refer to the British National Health Service, nor to have the particular form of the British system.

equality in access based on income inequalities than under CCHP, at least if the services under NHCS were reasonably adequate in quantity and quality, so that resort to the private market—largely by higher-income groups—remained limited. Under CCHP, by contrast, one might expect substantial differences in the benefit packages of different plans, with significant correlations between high- and low-benefit plan enrollees and high- and low-income groups. Geographical inequalities could be attacked by direct provision of appropriate health care facilities and services in areas presently medically underserved, whereas under CCHP there is a means for providing purchasing power to residents of such areas, but no means of insuring or providing the necessary supply of services. The maldistribution of physician specialists might be amenable to rectification through some form of planning mechanism that would coordinate specialty internship and residency allocations with specialty positions in the NHCS, the latter determined by patient needs.

I have drawn only the barest sketch of two polar alternatives to restructuring the health care system. What I hope to have provided is a clear enough idea of their nature to allow their assessment with regard to the issues of patient, physician, and professional liberty. Does a sound account of individual or professional liberty as strongly favor the market approach as is often supposed, and what moral constraints does it place on any such restructuring proposals?

Constraints of Liberty

There are a number of liberty arguments to be considered. I shall first take up arguments appealing to the liberty or autonomy of physicians and the medical profession, and then consider arguments based on patient liberty. One method of evaluating such arguments would be to develop and defend a general political philosophy, specifying the place and importance of particular liberties alongside other political values such as equality and human welfare. Patient and provider liberties within the health care system would then be derived from this more general account of liberty. Any such general political philosophy and account of fundamental liberties, however, would be highly controversial and could not be adequately discussed here. Moreover, it would shift our focus to a level of philosophical abstraction considerably removed from questions of health care restructuring. Instead, my strategy here will be to try to determine what liberties have been, or might be, thought to be substantially affected by the two paradigms of health care restructuring noted earlier. I shall then attempt to assess the importance of these particular liberties, and the extent to which they should constrain our attempts to improve the health care system. My hope is that without having to reach

agreement on the most general and fundamental questions of political philosophy (and in fact among many who are sharply divided on those questions), we can nevertheless agree on the importance of particular liberties in the health care system. I shall seek such agreement largely by analyzing precisely what liberties are at stake, how they will be affected, and what can be said in support of them.

Nevertheless, there are limits on the agreement to be expected from any such "middle level" analysis of liberty in the health care system. In particular, libertarian political theorists who ascribe primary importance to individual liberty, rejecting the redistributive demands of other political values such as equality or human welfare, can be expected to resist much of what is to follow. They will reject the assumption made at the end of the first section of this paper that there is any moral right to even a "decent minimum" of health care that would justify the redistributive use of involuntary taxation to provide the poor with health care directly, as in NHCS, or with health care vouchers, as in CCHP. Libertarians in the health sector must by and large be engaged at the level of general political philosophy at which most substantive policy disagreements with them arise. Though I consider libertarianism to be ultimately unpersuasive. I make no attempt to show that here; but I shall indicate a few points that libertarians might accept in our arguments concerning the limits of liberty constraints.

Physician Autonomy. First, consider an argument directed against restructuring efforts to deal with geographical and specialty maldistribution. I have noted that past efforts to deal with these problems have had only limited success, and that one significant reason for this is that those programs have relied on the voluntary choices of physicians and medical students. Market incentives have not had the desired effect on these choices, in significant part because physicians possess a substantial immunity from the relevant market forces.¹⁰ We have considered briefly how the CCHP and NHCS might deal with these two problems. An argument that is often made against "socialized medicine," of which our hypothetical NHCS is an example, is that it is incompatible with a fundamental liberty that physicians share with all other Americans. That is the liberty to decide where one will live and what kind of work one

¹⁰ The extent of this market immunity is in dispute. See, for example, William B. Schwartz, Joseph P. Newhouse, Bruce W. Bennett, and Albert P. Williams, *The Changing Geographic Distribution of Board-Certified Physicians*, *NEW ENGLAND JOURNAL OF MEDICINE* 303 (October 30, 1980), pp. 1032-1038. They suggest that board-certified specialists have diffused into non-metropolitan areas more than is usually supposed, and that market forces have more effect on physician decisions about where to locate than critics of the market generally acknowledge.

will do. This liberty is in many moral theories a fundamental and important moral right. It is often construed as part of a more general personal liberty, which might be characterized as the liberty to form and pursue one's own plan of life or conception of the good.¹¹ Where one lives and what work one does are central features of any person's plan of life, and to deny persons the right to make these decisions themselves is to fail to respect their status as autonomous persons. It would be to deny a fundamental liberty that we are otherwise prepared to infringe on only in very few cases, such as a military draft for national defense. The market approach, illustrated by Enthoven's CCHP, would seem to possess a significant advantage over NHCS, an advantage commonly claimed for markets generally, of reliance on voluntary choice and rejection of coercive measures. The advantage, however, is illusory.

Under the NHCS, no physician would be conscripted into service in a particular area of specialty, nor would any be prohibited from entering private practice in any area or specialty.¹² Training opportunities in particular specialties would be determined by planning processes geared to patient needs, as would available positions within the NHCS in different geographical areas. The planning process would aim at making the supply of health care services by area and specialty better conform to health care needs than it now does for reasons of the sort noted earlier.¹³ Physicians would have to go into specialties and areas where there were jobs. But this, of course, is the same constraint that virtually everyone else is already subject to, whether we are teachers, or engineers, or carpenters. And few would suggest that our being subject to such constraints violates any fundamental moral (or for that matter legal) liberty or right.

¹¹ See, for example, the otherwise different theories of John Rawls, *A THEORY OF JUSTICE* (Cambridge: Harvard University Press, 1971); and Alan Gewirth, *REASON AND MORALITY* (Chicago: University of Chicago Press, 1978).

¹² My argument in this paragraph parallels that of Norman Daniels in, *What is the Obligation of the Medical Profession in the Distribution of Health Care?* *SOCIAL SCIENCE AND MEDICINE*, Vol. 15F (1981), pp. 129-133.

¹³ One might object that planning processes are not available to successfully match supply with demand as I have supposed. I take no position on this issue in this paper, but if it is correct it is an important practical objection to the NHCS alternatives. (It is analogous to the objection against CCHP that it is not practically possible to make health care markets substantially competitive.) My concern is with the principled objection to the planning alternatives of an NHCS that even assuming it planned effectively, the use of governmental planning measures is inherently coercive and violates a substantial physician liberty.

The freedom or liberty to live where one wants and to do the work that one wants is what is usually called a negative liberty. It is a liberty, or right, to be free from certain forms of coercive interference by other persons in making and carrying out our choices. It is not a positive freedom or right to have others provide one with the particular job one wants in the area that one wants it. In many academic disciplines today, including philosophy, there are many more trained Ph.D.s who would like college teaching jobs than there are jobs anywhere, much less in areas of choice. That is in many respects an unfortunate situation with distressing consequences, but it violates no fundamental moral right or liberty of those who cannot find the jobs they want. (This is not to say that such a situation does not represent an inefficient use of resources. In the case of physicians, whose training is heavily subsidized with public funds, the public has a substantial interest in seeing that effective planning processes exist to prevent similar health manpower inefficiencies.) Libertarians, commonly the most extreme defenders of individual liberty, defend no positive liberty of this sort.¹⁴ In this respect, they accept like most others that the array of alternative jobs in alternative locations from which persons should be free to choose is rightly constrained by competitive markets determining the supply of such jobs.

This implies that in the argument from individual liberty and freedom of choice, the government-intervention approach of a NHCS is at no disadvantage in comparison with the free-market approach of a CCHP. Physicians would not have under a NHCS all the freedom to choose specialty and area that they now have, but they now have so much choice only because they are significantly immune to market constraints accurately expressing patient demand and need. Granting what is certainly problematic, that a free-market plan like CCHP would succeed in realizing the conditions of a competitive market in the demand for physicians in different specialties and areas, it too would produce an array of choices determined by patient demand. And that is the same array of choices aimed at by the government-intervention NHCS approach. The market approach can, thus, produce no more freedom of choice in this regard than can the NHCS approach. And it can be no more compatible with a right or liberty to determine one's plan of life, where one will live, and what work one will do.

The preceding argument, that a NHCS provides in principle no less physician liberty than a CCHP, depends on the two plans offering roughly the same array of specialty and geographical career choices to physicians. Sometimes, however,

¹⁴ For a recent, prominent example of such a libertarian view see Robert Nozick, *ANARCHY, STATE AND UTOPIA* (New York: Basic Books, 1974).

the idea is not that liberty is greater under a market than under a government alternative because the range of options is greater, but because it is a greater interference with liberty to have the government determine the alternatives than to have the market do so. It is one thing, it might be said, for the impersonal forces of supply and demand to determine a new physician's specialty or location alternatives, and quite another for the personal decision of a government official to do so. Many persons seem to resent government constraints when they would not resent similar market constraints. Is this preference for the market on grounds of liberty justified?

A common understanding of social freedom or liberty is that it consists of the absence of interference by other persons with our actions. Coercion interferes with liberty, and coercion results from the intervention of persons but not from the limitations of natural circumstances. Thus, you coerce me and interfere with my liberty if you forcibly restrain me from leaving an area, but a storm that washes out a bridge and also prevents me from leaving the area does not coerce me or interfere with my liberty. I may regret the storm, but I will resent your interference. In this view, in a nutshell, liberty is understood as non-interference, and interference comes only from other persons, not from natural forces.

This might help to explain the preference for the market over the government on grounds of liberty if the market is understood as a natural force rather than as the interference of other persons. One difficulty with this line of reasoning is that the limitations on choice imposed by a market are the result of the market behavior or actions of other persons, not natural forces, though those persons and actions are not always obvious or easily identifiable. More important, in any case, is whether the forces determining and limiting alternatives are subject to human control and alteration, not whether they are personal—or impersonal and natural. Market limitations are subject to human control, and can be altered by various forms of social intervention. Consequently, I believe the view cannot be sustained that market limitations on one's choices represent no diminution of liberty or less than would a similar limitation from government action.

I shall turn now to the problem of cost containment where there is a significant physician autonomy constraint on restructuring of the health care system. This autonomy constraint, however, must be carefully formulated and extracted from a larger group of supposed constraints that I believe are not defensible. An objection commonly raised against cost-containment restructuring proposals is that they wrongly impinge on the autonomy of the medical profession. It is useful here to distinguish the autonomy possessed by physicians as individuals from that possessed largely by medicine as an orga-

nized profession. The autonomy of medicine as an organized profession or group essentially refers to the freedom of the profession from external controls of various sorts. Duane Stroman has distinguished four areas of control now generally possessed by the medical profession:

- (1) the diagnosis and treatment of patients;
- (2) the entrance requirements to the profession;
- (3) the organization of medical practice;
- (4) the financing arrangements for medical services.¹⁵

I want to examine briefly the case for retention by the profession of these four areas of autonomy, since it is reasonable to believe that each of them would be in varying degrees significantly curtailed by our two paradigms of health care system restructuring, CCHP and NHCS.

But first it is necessary to distinguish two importantly different bases for autonomy claims.¹⁶ Recall that the appeal to the liberty of physicians to decide where they would live and what work they would pursue was based on a moral right or individual liberty that all persons as individuals possess. Such a moral right or liberty entails an entitlement against interference with that liberty, which others are morally bound to respect. If we turn to the four areas of control now largely possessed by the medical profession, there seems no plausible argument that that control is based on any basic liberty or moral entitlement of either physicians as individuals or medicine as a profession. Only the first area of control, the diagnosis and treatment of patients, is clearly a liberty claimed by individual physicians. The latter three areas of control are to a significant extent claimed and exercised by medicine as an organized profession. Basic moral rights, however, including any right to fundamental liberties, are (or are reducible to) the rights of individual persons, not social groups. But even if the profession's autonomy claims could all be reduced to the claims of individual physicians, the crucial point is that those latter claims are not plausible candidates for basic moral rights. Rather, if the four areas of control are morally justified and rightly respected by others, that is because various good consequences result from placing and leaving that control in the hands of the medical profession.

This distinction between a liberty that is a basic moral right of all and a liberty that is granted to particular persons because

¹⁵ Duane Stroman, *THE MEDICAL ESTABLISHMENT AND SOCIAL RESPONSIBILITY* (Port Washington, NY: Kennikat Press, 1976), p. 98.

¹⁶ My discussion in this paragraph has benefited from a presentation by Stephen Scher to the research project, *Social Controls and the Medical Profession*, directed by Judith Swazey.

doing so will result in good social consequences is worth underlining. It is similar to a distinction in the law between fundamental legal rights that *cannot* justifiably be infringed upon merely because overall social welfare would be better promoted by doing so, and liberties that are assigned to particular persons because overall social welfare is best promoted by doing so. My suggestion is that each of the four liberties or areas of control noted above are liberties of the latter sort, and therefore ought to be maintained only if it is reasonable to believe that good consequences accrue from doing so. They are not basic moral rights that must be respected independent of the social costs and consequences of doing so.

Any comprehensive assessment of the consequences of changes in these four physician liberties that CCHP or NHCS would make is obviously beyond the scope of this paper, but something can be said. The strongest case for physician autonomy concerns the first aspect of control above, the diagnosis and treatment of the patient, though even here note that the physician is autonomous at most in his recommendation concerning treatment. The patient, through the requirement of informed consent, retains the right to accept or reject treatment recommendations. An important basis for physician control of patient care lies in the special training and knowledge of physicians in diagnosis and treatment, and the lack of such training and knowledge in the average patient. Given the complexity of medical treatment and the extent to which it is at least arguably an art, it is difficult if not impossible to specify fully rules, regulations, and procedures for medical practice. Significant physician discretion is necessary in judgments about diagnosis and treatment. This is a defensible area of physician autonomy, not as a basic moral right, but as a socially desirable liberty. I shall have more to say about this first area of control shortly, but I will contrast it now with the other three.

The special training and knowledge of physicians seems not sufficiently related to the organization or financing arrangements of medical practice to make a persuasive case for sole control by individual physicians or the medical profession. There is, perhaps, more of a case for physicians controlling standards and procedures for entrance into the profession, if their training gives them superior ability to judge the qualifications of other physicians. But as has often been pointed out, the organized medical profession has used this control in the past in ways contrary to the interests of patients and the public—in particular by controlling the number of physicians and thereby limiting competition and maintaining physician fees at high levels. Such conflicts of interest exist as well in the organization of medical practice and the determination of financing arrangements. The profession is often able to organize medical practice for the convenience and in the interests of physicians rather than patients. Likewise, fee-for-service financing obviously helps

maintain high physician incomes. In each of the last three areas of professional control, there is at most only a limited case for that control based on the special training and knowledge of physicians, and there are also significant conflicts of interest between the profession and patients (or the public). This suggests that good consequences to the public generally do not result from granting physicians or the medical profession sole control in these areas.

In the first area of control, the diagnosis and treatment of patients, the matter is more complicated. An old and strong professional tradition in medicine is that a physician, acting as the patient's agent, is to make diagnosis and treatment recommendations guided solely by the best interests of the patient. Two aspects of this focus on the patient's interests should be distinguished. First, the physician's own interests and the interests of other affected parties are to be set aside and disregarded, and the physician is to serve only his or her patient. Second, treatment recommendations are to be dictated solely by the patient's medical needs and not by financial considerations. The recommended treatment is then to be the alternative that provides the maximal sum of medical benefits minus medical risks, without regard to the financial costs of different or additional procedures. As Arrow and others have pointed out, special features of the health care process make some form of agency relationship, where the physician acts as the patient's agent, desirable from the standpoint of the patient.¹⁷ Various features of a typical physician/patient encounter contribute to the importance of the patient's ability to trust the physician to act in the patient's best interest. Patients often come to a physician in a state of anxiety, vulnerability, even fear. Something is wrong with their body, something they in all likelihood do not understand and about which they are worried. The care they receive may affect their future in dramatic, perhaps life-and-death ways. But medical care, while having great potential to benefit the patient, is rarely without uncertainties and risks, potentialities for failure and serious harm. And, of course, the extraordinary medical advances of recent decades have multiplied both the potential benefits and risks of harm.¹⁸ Because patients are often unable to determine their health care needs or the appropriate treatment, and because the product of medical care is identical with the activity of its production, patients are

¹⁷ Kenneth Arrow, *Uncertainty and the Welfare Economics of Medical Care*, *THE AMERICAN ECONOMIC REVIEW* 53 (1963), pp. 941-973.

¹⁸ I have discussed some of these features of typical physician/patient encounters, and their implications for the moral structure of the physician/patient relation, in a bit more detail in, *Legal Rights and Moral Responsibilities in the Health Care Process*, in *THE LAW-MEDICINE RELATION: A PHILOSOPHICAL EXPLORATION*, eds. S. Spicker, J. Healey, and H.T. Engelhardt, Jr. (Boston, MA: D. Reidel Publishing Co., 1981).

unable to test and evaluate the product for themselves before consuming it. And unlike most other commodities, in the case of severe illness there is little opportunity to learn to evaluate the product oneself, from one's own or others' past experience based on an adequate number of trials. All of this and more argues strongly, I believe, for a relationship between physician and patient that retains the traditional agency component of the physician making treatment recommendations solely in terms of the patient's best interests. But should such recommendations completely ignore financial considerations, as the second aspect of the agency relationship noted above requires?

Without passing judgment on any particular cost-containment proposal, it cannot be rational for cost considerations to be systematically ignored throughout the health care system. Nor are they. Much evidence indicates that cost considerations affect diagnosis and treatment. Current health insurance arrangements may make it rational for a particular physician and patient to ignore the true costs of alternatives when choosing services covered by insurance. But this can only be a rational arrangement if appropriate cost considerations have been taken account of in a different manner or at a different place in the decision process. It is a familiar truism that health care competes with other desirable goods and services for limited consumer dollars. A health care system that systematically ignored costs and attended only to possible marginal benefits of diagnostic and treatment procedures would be irrational; it would overinvest in health care in comparison with other goods. This in turn means that the two components of the agency relationship noted above require qualification.

Whatever limits on the use of possibly beneficial health care are reasonable limits due to cost are also reasonable limits on the liberty of physicians to do all that is medically possible for their patients. Programs that attempt to make health care markets more competitive (like CCHP) and programs that place ceilings on health care expenditures (like NHCS) are explicitly designed to give financial considerations a greater impact on health care utilization. While this limits a physician's liberty to do all that is medically possible for his or her patient, it does so unjustifiably only if the cost constraints are themselves unreasonable cost limitations, not merely because they are cost limitations. There is no justified physician liberty to act for one's patient immune from all cost considerations.

Nevertheless, patient trust within the physician/patient relationship remains an extremely important value in the health care delivery system, and so cost-containment measures should be designed to preserve trust as much as possible. One suggestion is to limit costs at the macro-allocation level, determining in overall budgetary decisions the facilities, treatments, laboratory procedures, and so forth that will be available to

physicians.¹⁹ Within the constraints of available resources, the physician could then continue to do his best for his patient, and to recommend treatment on medical grounds independent of financial considerations. The patient, in turn, can continue to trust that the physician's treatment recommendation is made solely on grounds of the patient's health care needs and interests. While everything that might be medically possible in the absence of cost-considerations will not be done, that will violate no one's legitimate claims if there are sound reasons to adopt cost-containment measures, and if they fall equitably on different groups. Physicians would retain a conditioned autonomy to do their best for their patients.

I shall make one comment and express two reservations concerning this strategy for preserving this aspect of physician autonomy. The government-intervention NHCS approach seems better suited to this strategy than does the market approach. CCHP attempts to realize cost containment in large part through HMOs, which employ capitation charges and funding, thereby putting market pressures on the physicians who order most health care services to limit their doing so. But as has often been noted, this intentionally introduces financial considerations into a physician's treatment decisions for individual patients, and so it is probably a greater potential threat to patient trust and the agency relationship.²⁰ The first reservation about this macro-strategy for cost containment is whether reasonable regulations and guidelines could be formulated to limited available treatments and procedures. Many believe that medicine is so complex and, significantly, an art, and each patient's situation so different, that rules and procedures for good medical practice reflecting cost constraints could not be formulated. The more this is so, the more limited is this macro-strategy. The other reservation is about the extent to which patient trust that physicians will act only for their welfare would survive when it is clear that the overall health care system is constrained by financial considerations. Patients, and that of course means all of us, must come to understand that this trust is not incompatible with attention to cost. I believe the first reservation raises the more important and complex issue, and that much of the case for market versus government regulatory strategies to achieve cost containment may turn on it. It may be possible to adopt a more complex combination of market and government regulation approaches that reflect the strengths of each. There

¹⁹ This proposal has been made by Norman Daniels in *Cost Effectiveness and Patient Welfare*, in *RIGHTS AND RESPONSIBILITIES IN MODERN MEDICINE* (New York: Alan R. Liss, Inc., 1981), pp. 159-170.

²⁰ In fact, it is probably the most common criticism of HMOs that they place financial constraints directly on physician treatment decisions, and so are likely to produce an under-utilization of health care services.

are, of course, other important moral issues raised by cost-containment measures besides physician liberty. Perhaps the most important is whether the effects of cost-containment measures fall equitably on various groups within society, most notably on the poor, who are especially vulnerable.

Inequalities in access associated with income inequalities raise few substantial physician liberty arguments that have not already been considered. Some physicians prefer not to treat lower-class or poor patients, or not to live in medically underserved areas. But their freedom to act in those ways is not violated by either market or government intervention approaches to those problems, as has already been discussed. Physicians may have a professional right to set their own fees, which contributes to inequities in access to or utilization of health care between the poor and nonpoor. But there is no right to do so significantly free from market forces. Any defensible freedom of this sort is compatible with the increased market pressures on fees that a CCHP is designed to bring. Those market pressures may force most physicians out of individual, fee-for-service practice into large-group, prepaid comprehensive services. Similar forces seem to affect lawyers and providers of many other goods and services. Whether or not such changes are desirable, physicians, like others, possess no fundamental liberty to practice on an individual, fee-for-service basis that is violated by market forces that cause them to change their practice structures.

Under an NHCS, most physicians would be salaried, and so would work neither on a fee-for-service basis nor in private practice. Would either of these features of an NHCS violate any fundamental liberty of providers? The freedom to work on a fee-for-service basis is an aspect of professional autonomy that now happens to exist, though it is changing substantially, but I have argued that it is not a basic moral right or entitlement. In any case, neither CCHP nor the hypothetical NHCS that I have sketched prohibits physicians from entering private, fee-for-service practice if they choose. Nevertheless, a NHCS would make it effectively impossible for most physicians to work in private practice, whether individual or group, rather than for the government. Would this infringe on any fundamental liberty of physicians? Consider two other sorts of cases in which the government now makes it virtually impossible for persons to pursue a particular vocation in "private practice." It is widely agreed that there are "public goods" reasons for the government to provide and guarantee the universal availability of police protection and national defense, and reasons of justice and equal opportunity in the case of elementary and secondary education.²¹ As a result, most police, soldiers and teachers are

²¹ Economists' use of "public goods" is discussed in most economics textbooks, and at more length in James Buchanan, *THE DEMAND AND SUPPLY OF PUBLIC GOODS* (Chicago: Rand McNally, 1968).

salaried employees of the government. This is not seriously thought to impinge on a fundamental liberty of would-be policemen, soldiers, or teachers to work in private practice rather than for the government. Nor should it be thought to do so with physicians. So far as I can see, then, there is no substantial moral liberty argument to set against moral claims to remove inequities in access to and utilization of health care between the poor and nonpoor.

Patient Liberties. Do any fundamental patient liberties either constrain possible restructuring of the health care system or favor the market or government approaches to restructuring? One argument of patient liberty opposes the alternative of a government provider (NHCS). Personal preferences vary for health care versus other goods, and they vary for different kinds and amounts of health care. Therefore, economists often argue, individual preference satisfaction will be maximized by an alternative of income transfers that allows consumer choice of desired health care (as in CCHP)—as opposed to a program that allocates the same funds for the direct provision of a uniform level of health care (as in NHCS). Liberty to allocate one's funds is here argued to be necessary for maximizing consumer preference satisfaction, given any particular distribution of income, and for maximizing welfare if welfare is defined in terms of preference satisfaction. This defense of consumer liberty and the market (or cash transfers) over government intervention (or in-kind transfers) is an instrumental argument to the effect that consumer liberty will lead to the maximization of consumer welfare. But when applied to actual market and government institutions, the argument is more complex, since it requires an evaluation of the actual consequences of those institutions for consumers' welfare.

This argument depends on at least two central and problematic claims. The first is that human welfare is correctly characterized in terms of preference satisfaction. Among alternative views of human welfare, perhaps the most important for our purposes here is the satisfaction of "objective needs," one of which is health care. The second claim is that consumer choice in the marketplace leads to maximization of preference satisfaction. If we characterize preferences as economists often do, in terms of revealed preferences, those expressed in market behavior, then it probably is necessarily true that the consumer choice alternative maximizes preference satisfaction. But, of course, the satisfaction of revealed preferences, no matter how manipulated or uninformed, is an extremely implausible account of human welfare. Many of the conditions of perfectly competitive markets must be satisfied in order to claim at all plausibly that satisfaction of revealed preferences maximizes welfare. These conditions include among others the availability of desired alternatives (here, health plan packages) and the availability of information about these alternatives (for exam-

ple, the complex of benefits and exclusions in various packages), the capacity of the consumer to compare these packages in terms of how well they fit his or her desires for health care, and the consumer's ability to select free from mistakes or irrationalities the one that best fits personal desires.

It is obvious that under CCHP or any other possible market approach, the necessary assumptions are unsatisfied: Alternative health plans are limited, consumers lack or cannot understand much relevant information, and they exhibit various mistakes and irrationalities in their choice of alternatives. Whether liberty favors the consumer freedom of choice/market approach (or CCHP), as opposed to the government/in-kind provision approach (or NHCS), is a complex matter depending on whether, on balance, the market approach with its various defects better promotes patient welfare than does the direct provision of some level of health care services. I doubt that we possess the information necessary to estimate with much confidence where the balance of welfare maximization lies. If so, then it is far less obvious and more controversial than is often supposed that considerations of patient or consumer liberty (quite apart from other considerations) support a market rather than a government provision approach to health care.²²

A second patient liberty that is affected by some health care reform proposals is the liberty of patients to choose their own physicians. The market approach, with its competing health plans, seems more in accord with this liberty, though in CCHP consumers would generally choose only groups of physicians in an HMO. But it would be possible to build a significant degree of choice of physician into a NHCS in various ways; for example, persons could be given the right to change physicians within the NHCS. At least two reasons support maximizing patient freedom of choice among health care providers. First, and most obviously, it will allow persons to leave a provider with whom they are dissatisfied. Second, the patient trust necessary for the agency relationship between patient and physician is likely to be better promoted when the patient has significant freedom of choice of the provider on whom that trust will be bestowed. Against these considerations, it may be more efficient and cost-effective in certain cases to place some limits on the choice of physicians provided to patients. These cost considerations are not irrelevant. In the case of fundamental rights, such as the right to a fair trial, the right cannot be denied merely because it would be cost-effective to do so. But the choice of provider does not seem to be subsumable under any fundamental individual liberty, or to be a basic moral right or requirement of justice, such that we must disregard its cost.

²² Other arguments for preferring in-kind provision of goods or services rather than transfer payments can be found in Lester Thurow, *Government Expenditures: Cash or In-Kind Aid?* PHILOSOPHY AND PUBLIC AFFAIRS 5 (1976), pp. 361-381.

However, one sort of proposal for limiting freedom of choice of provider is morally problematic. Unlike what is proposed under either CCHP or NHCS, at present many of the poor have most of their health care expenses funded through Medicaid. It is sometimes proposed, as a cost-containment measure, to limit the freedom of Medicaid recipients to choose their own health care providers.²³ In my view, there is no basic and substantial claim of moral right or justice to choose one's health care provider; thus, such an action would violate no basic right. However, there are serious equity implications if this curtailment of choice falls only on the poor. Such a change would likely further promote a separate health care system for the poor, which they must use if they are to receive health care at all, while retaining a sector with more choices for the nonpoor. If cost containment then falls disproportionately on services for the poor, this would further undermine the adequacy of health care for the poor. It is because of their effects on equity, rather than because there is a basic moral right to choose one's own health care provider, that such proposals are probably morally unjustified.

One final patient liberty would be infringed upon by a strong equal-access principle permitting no one to have any health care services that are not provided to all others with comparable health care needs. Using this principle, whatever health care services are provided for all, no one would be permitted to acquire more. In the NHCS alternative, no additional private market would exist to allow some to purchase extra services. Under CCHP, various revisions would be necessary to satisfy this principle, presumably including elimination of differences in benefit packages between health plans.

The distribution of very few goods or services in this country is regulated by a strong principle of equal access. Votes are distributed one, and no more than one, per adult citizen, justified by features and principles of democratic political theory. But it is difficult to identify other goods or services for which there is a strict prohibition on obtaining more than anyone else has. Even with goods meeting basic needs and provided by the state, such as education and police protection, persons are not prohibited from purchasing more and/or better goods in the private market than one provided publicly. As Amy Gutmann has noted, such a prohibition would leave people free to spend their income on non-essential goods such as vacations or luxury cars, but not on an essential goods meeting a basic need like health care.²⁴ Since money is an all-purpose means to many goods and services, freedom to spend it can plausibly be viewed as part of the personal liberty necessary to form and

²³ This freedom is already significantly limited by the reluctance or refusal of many physicians to treat Medicaid patients.

²⁴ Amy Gutmann, *A Principle of Equal Access to Health Care*, Appendix C in Part I of this Volume.

pursue a life plan. The more the spending decision significantly affects an important aspect of a person's life plan, as do most major decisions concerning health care, the more plausible it is to suppose that an important liberty is at stake. This is not to say that all such decisions to form and pursue a life plan are rightly protected—most notably they are not when a person's choices will lead to serious harm to others. But it is difficult to see how one person's decision to purchase more or better health care than is provided, for example, under an NHCS, would harm others who choose to use their resources elsewhere.

This appeal to the importance of the liberty to form and pursue a life plan may seem incompatible with the discussion above concerning whether the market approach dominates the in-kind government provision approach in maximizing consumer welfare. Why not there, as here, appeal directly to the importance of this liberty to support the market alternative that allows persons to allocate their resources between health care and other goods as they see fit? There, my argument was that various factors were likely to lead persons to fail in maximizing their welfare, even determined by their own conception of welfare, if all provision of services were determined by their choices as consumers in a health care market. This generates paternalistic reasons for the in-kind provision of health care services, as in the government approach. Here, there is no analogous claim that persons denied the liberty to use their resources to purchase more and/or better health care than is available to all would thereby be better off, in their own view of where their welfare lies. Nor would any such claim seem plausible. Consequently, no paternalistic appeal to the health care consumer's own welfare is available to support this strong equal-access principle in its overriding of a person's liberty to form and pursue a life plan.

In order for this strong equal-access principle to override the case for patient liberty, some other argument is necessary—an argument supporting *equal* health care adjusted for differences in need, as opposed to services sufficient to meet the basic health care needs of all. Gutmann has appealed to Rawls's argument for the priority of the good of self-respect, and then has argued that inequalities in the health care system might undermine self-respect.²⁵ This argument would be plausible if the inequalities permitted included some persons having access to little or no needed health care, but we are comparing this strong equal-access principle with the alternative that guarantees to all a level of health care sufficient to satisfy basic health care needs (assuming these can be somehow defined). It is not clear why a system guaranteeing the satisfaction of the

²⁵ *Ibid.*

basic health care needs of all would seriously undermine self-respect, merely because some persons exercised a liberty to purchase more or better services than were guaranteed to all. Moreover, I believe that general arguments showing why health care is of special importance and ought to be distributed more equally than many other goods do not provide a persuasive case for this strong equal-access principle *in comparison with* a guaranteed minimum that meets the basic health care needs of all. In the absence of a persuasive defense of the strong equal-access principle, together with the significant liberty with which it conflicts, I believe that the strong equal-access principle should be rejected. Persons should be left free to purchase more and/or better health care than is guaranteed to all by either a CCHP or NHCS, at least so long as these provide the minimum that justice demands.

Am I My Parents' Keeper?

Norman Daniels, Ph.D.*

K

Must no one at all, then, be called happy while he lives; must we, as Solon says, see the end?

Aristotle, NICHOMACHEAN ETHICS, I-10

Opportunity, Age Bias, and Competition for Resources

If an acceptable general theory of distributive justice requires us to guarantee *fair equality of opportunity*, then a principle for the distribution of health care seems to follow.¹ Institutions delivering health care services, both preventative and curative, should also be governed by the fair equality of opportunity principle. In this view, health care is "special" because of its connection to the special social good, opportunity. Impairments of normal functioning might prevent an individual from enjoying the range of opportunities normal for his society. Health care needs may be defined as things we need to maintain, restore, or compensate for the loss of normal species functioning. Thus, meeting health care needs is as important as guaranteeing individuals that their opportunities lie within the normal range for their society. Though there are

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¹ The approach is developed in my *Health Care Needs and Distributive Justice*, *PHILOSOPHY AND PUBLIC AFFAIRS* 10:2 (Spring 1981) :146-179.

some problems in thus extending the notion of opportunity;² as we shall see, the distributive theory for health care that emerges is both rich and suggestive.

Still, some people may raise an interesting objection to this approach. Any distributive theory for health care, we might suppose, should account for the importance of meeting the health care needs of young and old alike. In our system, people over age 65 use health care services at roughly 3.5 times the rate (in dollars) of those below 65. In 1977, per capita expenditures for those over 65 were \$1745; they were \$661 for those age 19-64 and \$253 for those under 19.³ But, so goes the objection, if equality of opportunity were the relevant principle of distributive justice, we could not justify such extensive use of health care services for the elderly. Their opportunities lie in the past and are no longer a matter of pressing social concern, especially if we concentrate on opportunities to enter jobs and careers (which I do not). Consequently, the objection continues, the opportunity principle cannot possibly provide a justification for our current distribution of health care services. Like the discounted future earnings approach to the problem of valuing lives, the fair equality of opportunity approach seems age-biased; it would discriminate against the elderly in a morally unacceptable way.

Of course, it might be possible to counter this accusation of age bias by arguing that it is our current practice, not the opportunity principle, which is age-biased. Some might argue that we spend too much on health care for the elderly; for example, in a last-ditch effort to extend life marginally or to prolong dying. One study shows that 50% of all hospital billings are to some 13% of the patients, the seriously chronically ill. About 40% of these "high-cost" patients are over 65, whereas only 15% of the "low-cost" patients are.⁴ We seem

² We are concerned with more than just opportunity to enter jobs and careers, but this weakens the argument Rawls offers for the equality of opportunity principle. Cf. John Rawls, *A THEORY OF JUSTICE* (Cambridge, MA: Harvard University Press, 1971), Sect. 14. I note some of the problems in *Health Care Needs*, pp. 169ff. For other criticisms, see Allen Buchanan, *The Right to a Decent Minimum of Health Care*, Appendix I in this Volume.

³ R.M. Gibson and C.R. Fisher, *Age Differences in Health Care Spending, Fiscal Year 1977*, *SOCIAL SECURITY BULLETIN* 42:1 (January 1979) :3-16

⁴ C.J. Zook and F.D. Moore, *High-Cost Users of Medical Care*, *NEW ENG. J. MED.* 302:18 (May 1, 1980) : 996-1002. The aged and chronically ill have become the major users of intensive care: 44% of all ICU patients at Massachusetts General Hospital were over 65 and 25% were over 75, yet only 17% of people in the hospital catchment area were over 65. Similarly, patients over 70 years old, a group excluded from some coronary care units in the past, were 32% of all admissions in another study. Cf., E.W. Campion, A.G. Mulley, et. al., *Medical Intensive Care*

compelled to employ life-prolonging technologies whenever we can, which is more frequently among the elderly. Yet we are blind to the impact of such a policy on the health prospects of the young. For example, in a context of rising costs and scarce resources, and in any case, of tightened public budgets, we are more willing to impose stricter eligibility requirements and lower budget ceilings on Medicaid—most of whose recipients are young women and children—than to alter our practices for the dying elderly. Such rationing, so the reply goes, is age-biased against the young (as is, it might be added, the special immunity shielding Social Security benefits when all other social welfare programs are being drastically cut).

I believe both the objection and the reply are so crudely drawn that they do not help us assess the opportunity approach to health care distribution. But they do serve to raise a prior, indeed, more interesting and general question: When is a distributive system, such as a health care system, age-biased? Moreover, they highlight the importance of the question by raising the spectre of age-groups competing for scarce resources, pitting father and son and mother and daughter against grandfather and grandmother. To be sure, honor thy father and thy mother! But how much? And how long? Once raised, the spectre of age-group competition for scarce resources threatens traditional values, like duties to the elderly, by eroding our confidence that we understand their limits. Similarly, the view that the elderly are entitled to support and deserve it, because of their past contributions to cooperative, productive schemes, also gives little guidance in answering the question "How much?"⁵ Other moral notions, like the injunction to respect persons equally, seem to give less guidance than we might hope.⁶ Yet these questions about competition for resources must be answered, and they will be answered, either by principle or by default. So we must look for a principled way to tell when distributive schemes are age-biased or fair.

I try to formulate more clearly the general question about age bias and compare it to other sorts of distribution problems in the next section. Because birth cohorts are transformed successively into different age-groups, and because we are con-

for the Elderly: A Study of Current Utilization, Costs and Outcomes, JAMA (forthcoming); G.E. Thibault et al., *Medical Intensive Care: Indications, Interventions, and Outcomes*, NEW ENG. J. MED. 302:17 (April 24, 1980): 938-942.

⁵ J.N. Morgan, *The Ethical Basis of the Economic Claims of the Elderly*, in SOCIAL POLICY, SOCIAL ETHICS, AND THE AGING SOCIETY, eds. B.L. Neugarten and R.J. Havighurst (Committee on Human Development: University of Chicago, 1976), National Science Foundation: U.S. Government Printing Office: 67-69.

⁶ A.R. Jonsen, *Principles for an Ethics of Health Services*, in SOCIAL POLICY, SOCIAL ETHICS, AND THE AGING SOCIETY, 97-105.

cerned with distributive principles that govern social institutions over time, I formulate a modified "prudent saver" model. Using this model, allocations such savers approve will be normally acceptable distributions between age groups. I then argue that the notion of an age-linked opportunity range will play an important part in the deliberations of such a saver, and this suggests how my opportunity approach to health care distribution can be spared the charge of age bias. Indeed, when this is properly understood, we gain an edge on important resource allocation issues that underlie many criticisms of the U.S. health care system and its treatment of the elderly. Next, I draw some lessons about the problem of equity between birth cohorts from a brief glance at the Social Security system. I conclude with some qualifications.

When Are Acts, Policies, or Institutions Age-biased? It is tempting to think about age bias or agism using the models of race and sex bias. Though philosophers have not written much about aging or age bias, the gerontological literature has drawn some clear parallels. The elderly are portrayed as a minority that is treated in unfavorable, even discriminatory, ways by the more powerful majority. Some, using methods commonly employed to measure the effects of racism (e.g., measures of economic inequality), have suggested that agism induces even greater inequality than racism or sexism.⁷ Others have pointed out ideological similarities. Crude age-related stereotypes are generated. These may have a psychological appeal, based on fear of aging and death, and a rationalizing function ("justifying" policies, like compulsory retirement), which together favor younger cohorts. These stereotypes notoriously interfere with the delivery of considerate, high-quality medical care and are reflected in derogatory hospital and nursing home jargon (and practices). Similarly, special problems arise from agist attitudes in mental health-care contexts.⁸

It is easy to think of cases in which appeals to age are morally wrong in much the way that certain appeals to race or sex are morally objectionable. A policy that cut off voting privileges for the elderly or required them to take a competency test (on the model of driver recertification tests), would be morally objectionable, even though we allow age to play a role in assigning voting rights to the young. Practices that excluded the elderly from certain kinds of housing would be similarly objectionable. Job discrimination against the elderly—or against a protected age-group (say those over 40)—has also received at-

⁷ E.B. Palmore and K. Manton, *Ageism Compared to Racism and Sexism*, *JOURNAL OF GERONTOLOGY* 28:3 (1973): 363-369.

⁸ Cf. R.N. Butler, *Age-Is: Another Form of Bigotry*, *GERONTOLOGIST* 9 (1969): 243-246; and R.N. Butler and M.I. Lewis, *AGING AND MENTAL HEALTH: POSITIVE PSYCHOLOGICAL APPROACHES* (St. Louis: C.V. Mosby, 1977), esp. 141-143.

tention, though not to my knowledge any sustained philosophical examination. Specifically, hiring practices and other job assignment and wage practices that appeal to age criteria and not competence seem morally objectionable in the way sex and race criteria do.⁹ Of course, there is an asymmetry here: We exclude the young (say those under 16) from job eligibility, presumably because there is an overriding social concern that there are better things than working the young should be doing for themselves. But this exception points us to the general issue: Age, like race and sex, seems to be a morally irrelevant criterion for a broad range of contexts.

To be sure, we have to unpack the notion of moral relevancy here if we are to get a useful explanation, and this difficult task is not one I can undertake here. Still, many cases are clear. Race is not an indicator of competency to perform a job, and it is morally objectionable to use it as a guide to hiring practices (except, possibly, in the context of certain compensatory practices, like affirmative action). Age is not an index of the likelihood of being a good tenant and so is morally irrelevant to rental practices. And where some associate a relevant trait (industriousness, intelligence, crankiness) with a generally irrelevant one (race, age), the associations usually are, in the important cases, false; that is, they are part of a racist or sexist myth.¹⁰ At best they are crude, statistical generalizations that are clearly unfair (by denying equal opportunity) to individuals, about whom the generalization is quite wrong.

Though these cases and considerations explain the temptation to draw parallels between the use of age, sex, and race criteria, other cases challenge it. Consider the question in a rationing context that has been criticized as age-biased by many, namely the policy that existed (at least implicitly) in the British National Health Service (NHS) of not giving renal dialysis to those over age 65.¹¹ Let us suppose that dialysis is

⁹ A qualification may be needed here: Age criteria may not function exactly like race or sex criteria in such contexts. It might not seem imprudent for age-related practices, like seniority, to be given weight. Indeed, from the perspective of a prudent person allocating job opportunity over a lifetime, it might seem worth trading greater training options in his youth for greater job security in his later years. No such reference to race or sex criteria is plausible, largely because the prudential saver model allows greater freedom here than where distributions more clearly cross the boundaries between persons. See section titled "Does Aging Pose a Distinct Distribution Problem?"

¹⁰ Cf. my *IQ, Heritability and Human Nature*, in *PROCEEDINGS OF THE PHILOSOPHY OF SCIENCE ASSOCIATION*, 1974, ed. R.S. Cohen (Dordrecht: Reidel, 1976): 143-180. It is important to remember that the elderly are a non-homogeneous group; cf. C.C. Pegels, *HEALTH CARE AND THE ELDERLY* (Rockville, MD: Aspen, 1980).

¹¹ Cf. A. Caplan, *What Are the Morals of Our Treatment of Renal Failure?*, in *SOCIAL RESPONSIBILITY: JOURNALISM, LAW AND MEDICINE*, ed. L.J. Hodges (Washington and Lee: 1980): 32:50.

medically effective for elderly patients, permitting relatively normal functioning, so that the age criterion is not merely a guide to medical suitability. Does the appeal to such an age criterion in rationing constitute an age bias, by which I mean a morally unacceptable discrimination? Our earlier considerations suggest it does. If the sole difference between two persons, one age 64 and the other age 66, is their age, and that is the basis for deciding who gets dialysis, then it surely *looks* like the rationing scheme is age-biased in a morally objectionable way.

But the rationing case is more complicated; contrary considerations come to mind. Consider two rationing schemes. Scheme A involves a direct appeal to an age criterion: No one over age 70 is eligible to receive any of several high-cost, life-extending technologies; e.g., dialysis, by-pass operations, or angioplasty. Because age rationing greatly reduces the utilization of each technology, resources are available for developing all of them. Scheme B rejects age rationing and allocates life-extending technology solely by medical need. As a result, it can either develop just one such technology, say dialysis, making it available to anyone who needs it, or it can develop several and ration them by lottery. Given our earlier discussion, Scheme A seems age-biased in a way that B is not. The effect of B, however, is to reduce the likelihood of people under 65 reaching a normal life span, 70. Some would contend that Scheme B, though it does not refer to an explicit age criterion, has a systematic negative effect on younger age-groups and is in that sense age-biased in a morally objectionable way.¹² Of course, the contention depends on showing that maximizing the likelihood of reaching the normal life span is morally preferable to merely extending life wherever we can, without any reference to age. Considered moral judgments differ on this and related issues (and in ways that may reflect our interests given our ages); moreover, strong considerations and arguments incline us in opposing directions. The problem is made to seem even more intractable because these moral disagreements are set in the context of a distributive framework that makes one group's gains look like another group's losses.

I would like to suggest a different distributive framework for conceiving the problem, one that permits a fresh theoretical perspective. The perspective can be introduced by observing an important fact about certain health care insurance schemes. Suppose we have a health care financing scheme that guarantees substantial access to medically needed health care services for the elderly. The details of the scheme do not much matter here. It could be a universal national health insurance scheme

¹² The allocation issues here are numerous. For example, the young might prefer investing in preventive efforts, like health-hazard regulation, whereas the elderly may not benefit from such long-term investments.

with subsidization for those who cannot afford premiums,¹³ or it could be a composite financing system that included private as well as publicly subsidized programs. But even a scheme that does not redistribute income raises the same issues if it is "community rated" and incorporates all ages into one risk-pool. The central fact is that health care needs vary with age, so the elderly will use certain health resources at a higher per capita rate than the working-age population. In 1977, the 10.8% of the population that was over 65 incurred 29% of the total bill for personal medical services. Consequently, any such insurance scheme involves a transfer of wealth from later birth cohorts to earlier ones, from younger age-groups to older ones. But if the insurance scheme continues over a long period of time, birth cohorts who are now transferring wealth (aid-in-kind) to their elders will eventually be the beneficiaries of such transfers from later birth cohorts. Consequently, any such health insurance scheme can be viewed over time as a savings scheme: Participation in the scheme transfers resources, in the form of contingent claims on health care services, from one's youth to one's old age. Of course, such savings are not "vested" assets, like money in the bank; but we are deferring resources from one point in our lives to another and so have a kind of savings scheme.

Notice how focusing on an institution—the insurance scheme—that operates through time forces a shift in our perspective on the rationing problem. We are driven to converting the synchronic or time-slice distribution problem we first raised, namely, how to ration health care resources between competing groups while avoiding age bias, into a diachronic perspective in which we are concerned with the treatment of the same people through the various stages of their lives. From this perspective—from my perspective—three questions about the design of the institution—here the insurance scheme—arise in a quite natural way:

(1) At what rate of savings should I defer the use of health care resources within my life?

(2) What health care benefits do I most need and want at each stage of my life?

(3) How can I be sure that my participation in the scheme involves equitable transfers between my birth cohort and both earlier and later ones, given the fact that economic and population growth rates vary through time?

¹³ Partly because of retirement policy and partly because of inequalities in income distribution throughout earning years, about 25% of the elderly are below or near the poverty line. The average older couple receives less than half the income of younger couples. Cf. Pegels, *HEALTH CARE AND THE ELDERLY*, p. 4.

The last question is familiar, of course, because of current worries about inter-cohort inequities in the Social Security system, and I shall return to these matters. The answer to question (2) will have a bearing on the answer to (1). I have raised these questions in the first person. But, because we are concerned with cooperative social schemes, it may be necessary to answer the questions from a more general perspective, that of a prudent saver—or from a more hypothetical construction in which the saver operates behind a “veil of ignorance” of appropriate thickness. I will return to this issue, but first I want to address the rationing problem I posed earlier, using the perspective suggested here.

Suppose I know I have available to me a lifetime health care allocation, say in the form of an insurance benefit package. However, it is up to me to budget, once and for all, that allocation or benefit package so that it is used to meet my needs and preferences over my lifetime. How would it be rational for me to budget it—given all the uncertainties about my future health, wealth, and family situation? One plausible proposal might be for me to reserve certain life-extending technologies for my younger years, reasoning that my doing so maximizes the chances of living a normal life span. I then might use the “savings” embodied in that restriction to provide myself with more social support services in my old age. I might reason that such services could vastly improve the quality of my years in old age and that such an improvement is worth the increased risk of a slightly shortened old age. I might then instruct—through my benefit package—providers to treat me accordingly; that is, to appeal to an age criterion in their utilization decisions concerning me. This package is intended to resemble the age-rationing scheme the British NHS apparently used for hemodialysis, and a rationale for the NHS scheme could be modeled on my reasoning about my package.

Under this scenario, although age is used as a criterion in the utilization decisions involving me and everyone else who joins the same insurance scheme, there is a minimal basis for suggesting my treatment is age-biased in a morally objectionable way. It might be thought that there is no bias here merely because I consent—buy into—the scheme. But the fact of my consent to the scheme is not the main issue here. Consent does not quite count for everything: Blacks or women might consent to race- or sex-biased treatments without thereby overriding all claims that the treatments are morally objectionable.¹⁴ As I

¹⁴ The issue is quite complicated and arises often in making moral judgments about race, caste, or sex practices in other cultures. Often we try to avoid the issue by discounting consent, say by labeling it “false consciousness.” But what if the consent seems genuine? Do such problems make the appeal to Kantian views of the person and hypothetical contracts all the more problematic, or all the more attractive?

suggest in the next section, there is an important difference between age and race/sex distribution problems, and this difference explains why age rationing in such schemes is not morally objectionable in the way race or sex rationing would be.

We are not in a position to answer the question: When are acts, policies, or institutions age-biased? But we have seen strong reason to think that not every appeal to an age criterion for rationing is as morally unacceptable as comparable appeals to sex or race would be. We must explore further why the cases are different.

Does Aging Pose a Distinct Distribution Problem? The distribution problem between age-groups is usefully contrasted with two distribution problems it somewhat resembles. Consider first whether the age-group problem is just a special case of the problem of obligations to future generations. After all, age cohorts are commonly referred to as "generations." And both seem to raise the issue of competition for resources: Present and future generations—just like age-groups—compete with each other. The problem of obligations to future generations is also sometimes formulated as the problem of finding a "just savings" principle. So too the issue of a fair savings principle arises in the age-group problem, at least if we view schemes that transfer income or health care benefits from younger cohorts to older ones as a kind of savings institution. What rate of transfer, what savings rate, is just? Moreover, there is another point of similarity: Transfer schemes operating through extended periods must be concerned that different birth cohorts enjoy equitable "replacement ratios." (The replacement ratio is the ratio of benefits to contributions.) This problem of equity strongly resembles the just savings problem between generations.¹⁵ Nevertheless, I think the differences between the problems of aging and future generations are greater than their similarities.

¹⁵ It is worth noting a point of contrast between the aging problem posed here and the just savings problem as it is discussed by John Rawls (cf. *A THEORY OF JUSTICE*, Sect. 44, 45). Rawls is primarily concerned with preserving adequate capital and non-renewable resources so that successive generations are in a position to maintain institutions of justice. In contrast, we are concerned with institutions that transfer income or aid-in-kind between age groups so that their consumption will yield just income-support and health care distributions through our lifetimes. Rawls's approach to the just savings problem involves his device of a thick veil of ignorance: We do not know which generation we will be in when we are choosing our principles of justice. Moreover, he imposed a motivational constraint on parties making the hypothetical contrast: They are concerned about the well-being of a generation or two in each direction (from their grandparents to their grandchildren). Contractors operating under such constraints would prudently grant each generation an equal claim on resources necessary to maintaining institutions of justice. In this way the just savings rate acts as a constraint on other principles of justice, such as

The major difference is that young birth cohorts are transformed in time into elderly cohorts; they age. But no current generation becomes a future generation. It follows that certain special features of the future-generations problem do not arise in the aging problem. We do not have to consider the great uncertainties about conditions of life in the very distant future; we do not have to worry about the puzzling conceptual problems that may attend positing obligations by existing people to non-existent ones. But the most important consequence of this difference between the problems is that some form of prudential reasoning is naturally appropriate to solving the age-group distribution problem in a way that it is not for the future-generations problem. I know I will grow old, or at least that I must prepare for the eventuality of growing old. So I have a concern for the structure of institutions that will help me defer the use of resources in a prudent way. In no such direct way does prudence make me concerned about saving resources for future generations. (Of course this contrast will have to be qualified somewhat in the next section, since we will ultimately be talking about prudence in a more hypothetical context.)

A further difference between the problems of aging and future generations is that different age-groups coexist and compete politically for social goods distributed in cooperative arrangements. Future generations are not here to fight for their interests. This difference may be an important psychological and political fact; it is less clear how relevant it is to the problem of deciding what arrangements are, in principle, just. It does, however, introduce some issues about the implementation of cooperative schemes and the contrast between ideal and non-ideal arrangements, to which I will return.

The fact that different age-groups coexist and share in a distribution scheme contemporaneously may make the age-group problem resemble more closely the distribution problems among other demographic groups (races, sexes, classes) than it does the future-generations problem. The similarity enhances the sense that we are concerned with a synchronic distribution problem, a time-slice in which competition rages. Moreover, as we have seen, many of the same issues arise in all these demo-

the *difference principle*: No society can *maximin* (the maximization of the minimum level of primary goods) unless it has set aside the resources required by the just savings principle. The question (3) posed in the last section, about equity in replacement rations between birth cohorts participating in the scheme, may need for its resolution arguments based on such a hypothetical contractual apparatus. But I think that answers (1) and (2), about the rate of savings and the content of the benefits "saved," may be approached more directly, with a less "veiled" form of prudence. Still, the answer to (3) will constrain answers to (1) and (2), much as the savings principle constrains the difference principle.

graphic competitions. The moral arbitrariness of certain appeals to age resembles the arbitrariness of appeals to race or sex. Similarly, we are concerned that our treatment in cooperative schemes should reflect the fact that we are all equally to be considered as persons, regardless of age, sex, race, class, and so on.

But the same fact that makes the aging problem different from the future-generations problem also makes it different from the distribution problem involving other demographic groups. Young birth cohorts age and are transformed into older age-groups. We become old, but we do not change generations, race, sex, or (usually) class. As Zeckhauser and Viscusi put it, "[T]he elderly comprise a minority group we can all hope to join."¹⁶ This basic fact points to the naturalness of the suggestion that we think about cooperative social schemes that bear on aging in prudential terms, even though we may have to abstract somewhat from the perspective of a real individual; that is, from the economist's "prudent saver."

It is now possible to explain why appeal to an age criterion in some rationing schemes works differently from appeals to race or sex criteria. From the perspective of institutions operating over time, the age criterion operates within a life and not between lives. One important criticism of utilitarianism, advanced by Rawls, is that it extends a principle of individual rational choice appropriate to distributions within a life into a social principle of rational choice that crosses personal boundaries.¹⁷ Thus it is rational and prudent that I take from one stage of my life to give to another, in order to make my life as a whole better. But it is morally problematic just when society can take from one person to give to another in order to maximize, say, total happiness. Rawls's point would explain the deep problem facing any attempt to ration life-extending resources by race or sex: In this case, taking from some to make society as a whole better off would fail to respect the difference between persons. But now we see the difference between the race and aging cases. Rationing by age criteria looks like a case of crossing personal

¹⁶ R.J. Zeckhauser, and W.K. Viscusi, *The Role of Social Security in Income Maintenance*, in *THE CRISIS IN SOCIAL SECURITY: PROBLEMS AND PROSPECTS*, ed. M. Boskin (San Francisco: Institute for Contemporary Studies, 1978), p. 54. Paul Samuelson offers the classic treatment of this perspective on inter-cohort transfers in *An Exact Consumption-Loan Model of Interest With or Without the Social Contrivance of Money*, *JOURNAL OF POLITICAL ECONOMY* 66:6 (December 1958): 467-482.

¹⁷ Cf. Rawls, *A THEORY OF JUSTICE*, Sect. 5. Cf. also Derek Parfit, *Later Selves and Moral Principles*, *PHILOSOPHY AND PERSONAL RELATIONS*, ed. Alan Montefiore (London: Routledge & Kegan Paul, 1973): 137-169; Rawls, *Independence of Moral Theory*, *PROCEEDINGS AND ADDRESSES OF THE AMERICAN PHILOSOPHICAL ASSOCIATION* 48 (1974-1975): 5-22; and Daniels, *Moral Theory and the Plasticity of Persons*, *MONIST* 62:3 (July 1979): 265-287.

boundaries only if we take a "time slice" perspective. Once we take the perspective of institutions operating through time, the appearance of crossing boundaries between persons fades and we are concerned primarily with distribution through the stages of a life. No comparable point is true for rationing by race or sex over time.

This general point is not to deny there are some irreducible interpersonal aspects of the cohort issue. For example, the question of equity in replacement ratios between birth cohorts raises an issue of equity between persons in the face of changing economic growth rates or birth rates. This issue aside, however, the core of the age-group problem has a different philosophical texture from either of the other distribution problems we have considered.

The distribution problem between age groups must, of course, be set within a framework that takes more general issues of distributive justice into account. This might suggest there is no special problem of distribution between age groups. One might, for example, think Rawls proceeds as if there is no special problem of justice. His *difference principle* requires that the worst-off groups are to be made maximally well off as measured by an index of primary social goods, which includes basic liberties, opportunity, income, wealth, powers, and self-respect. But the value of the index for a representative individual is determined by his share of primary goods over his lifetime; thus it is to include what social or economic mobility he will enjoy or regret. This lifetime index assignment might suggest that Rawls ignores the problem of distribution between age-groups, perhaps dismissing it as a problem for individual savings. But Rawls's simplifying assumption involving the index is not a sleight of hand that makes the problem of distribution between age-groups disappear.

The problem we are concerned with reemerges as soon as one tries to arrange basic social institutions that embody the more general principles of justice over time. For then the problem of rationing income or health care benefits throughout the stages of a life arises again, and this problem requires the establishment of cooperative schemes or institutions of a rather basic sort. The difference principle, to continue with the Rawlsian example, maximizes the index level of representative, worst-off individuals over their lifetimes. But several cooperative "savings" schemes might be compatible with satisfying the difference principle. That is, the more general theory of distributive justice is silent on the age-group distribution problem except where inter-cohort transfers or savings schemes interfere with the difference principle. Moreover, if I am right that health care institutions should be governed by the fair equality of opportunity principle, as I later extend it, then at least this "savings institution" constrains the difference principle.

Prudence and Aging

I have been suggesting that we approach the problem of competition—or distribution—between age-groups from the perspective of institutions that operate through time to defer resources from one stage of life to another. But in converting what began as an inter-personal distribution problem, with all its attendant worries about age bias, into an intra-life problem of rational or prudent savings, my approach encounters an objection, one with a paradoxical air about it. The objection is that the shift to talk about prudential allocations of resources within a life, far from telling us when distributions between age-groups are just or age-biased, prohibits us from raising the question about age bias at all. For, when a person favors one stage of life over another, even his inadequate or inappropriate allocation to a stage of his life—or, in a cooperative scheme, to an age-group—is not viewed as immoral or unjust. It is merely imprudent, at worst.

Consider some examples. Olga is a figure skater who has invested very heavily in the development of certain talents and skills while neglecting others. She has ignored the development of critical social skills, has acquired only the narrowest education, and has led an austere, even grim, childhood and youth. If she achieves wealth and fame in her career—becomes a star of the Ice Capades—then she may feel the gamble has paid off. Later stages of her life will reap benefits from the sacrifices of earlier stages. But what can we say about the extreme hardship and sacrifice she experiences in her childhood? They might be imprudent (even if the gamble pays off). But it seems merely metaphorical to say she was “unfair” to her childhood. So, if the intra-life model precludes saying that the plan is unfair to a life stage or biased against it, then it looks like we are not solving the problem we thought existed. Of course, it does make a difference whether the plan for Olga is hers or is imposed by ambitious parents and skating instructors, perhaps even with “false consciousness” on Olga’s part. But here the unfairness to Olga is both that she was denied resources and opportunities thought normal to development and that she was denied autonomy, the chance to design her own life plan.

Consider a case in which Olga’s plan is writ large into a social policy, a kind of initiation rite. From age 20 through 30, people are given just a living stipend for the work they do. They accumulate no property and lead austere lives. After the initiation or “social indenture” period, they are presented with an annuity policy that enhances their income at a later stage of life, or they are given some other award, perhaps just acceptance as full-fledged citizens who benefit from the labor of the next birth cohort going through the process. Is such a scheme age-biased? Depending on details, a central complaint might be that the system too severely restricts certain liberties, which we may see

as a social good that should not be rationed or “saved” in this way. But, liberties aside, suppose the system were stable, seemed to reflect a shared conception of a rational plan of life, and appeared to be as voluntary as any well-entrenched social custom involving initiation rites. We might be inclined to say it is imprudent for the indentured cohort to “save” in this fashion; *they* might disagree. Of course, we might not be able to say even that if the “return on investment” for participation is higher than in alternative schemes. In any case, does our ability to complain about age bias disappear?

The examples really raise two issues. The first is primarily terminological. Ordinarily, we do not import moral notions, like fairness and justice, into prudential contexts, viz. allocations within a lifetime. But the proposal here is that our proper standards for judging the fairness of distributions between age-groups—which do exist as distinct groups of people, in contrast to stages within a life—is prudential. We are to view the different age-groups as if they were but stages of one life, for, from the perspective of cooperative “savings” schemes operating through time, each person is treated at the different stages of his life in just the same way the different groups are. Accepting the proposal would be grounds for ignoring the suggestion that the language of prudence bars us from raising issues of justice.

But the examples also point out that what is prudent from the perspective of one rational person or group of persons may not be from that of another. The appeal to a prudential or rational savings model usually carries with it the notion of an individual with a given set of preferences or “conception of the good.” What is prudent is so from his conception of the good. How, then, can we use the suggestion that prudential reasoning is the key to solving the distribution problem for different age-groups? The social institutions that bear on saving encompass people with different conceptions of the good.

There are two main strategies. One is the proposal that we rely on market mechanisms to allow people every chance to express their own prudent preferences. The social task, then, is to make sure such markets function properly and that income distribution is initially just. Specifically, with regard to health care, one might look to a market for insurance schemes that differ from one another in their “rate of savings” for later stages of life. That is, some might have lower premiums and offer less coverage in later years; others might defer more resources, in the form of contingent benefits. People would then buy the package it is prudent for them to buy, given many facts about their situations, including their conceptions of the good, risk averseness, and so on. This approach converts with a vengeance the problem of age-group distribution into an individual savings problem: The social concern is to provide a setting in which individual rationing within lives can take place. But there is little room for social institutions to guarantee that

prudent allocation takes place. The second strategy is to modify the appeal to prudential reasoning by using a hypothetical agent, one that abstracts from certain features of individuals. Such an agent then seeks principles for the design of the relevant social institutions. I shall suggest a version of the second strategy that is appropriate to the "savings" problem for health care. In its general form the strategy is familiar as the hypothetical contractarian approach used by Rawls and others. But it is worth considering some limitations of the first strategy first.

The strengths and limits of the first strategy are revealed if we consider the way in which a rational consumer might think about the problem of chronic illness or disability. The long-term care such conditions require is a focal point of criticism of the treatment of the elderly. In our system, chronically disabled or enfeebled persons tend to be institutionalized much more frequently and earlier than comparable persons in other systems, e.g., the British or Swedish. Moreover, they are often institutionalized at inappropriate levels of care, and possibly at higher cost than alternative forms of treatment or services would involve. The incentives for such institutionalization are built into Medicare and Medicaid reimbursement schemes. The effects of such "over-medicalization" are serious, on both the mental and physical health of the elderly.¹⁸ Yet, as Christine Bishop points out, the uncertainties facing the onset and costs of disability make it an obvious candidate for insurance schemes.¹⁹ The rational consumer would presumably try to buy a package that avoided the features of our current long-term care system.

Any individual faces a significant, actuarially calculable chance of chronic illness or disability over his lifetime; the chance increases with age (let us leave aside those disabled from birth or facing a known genetic disposition to disability). Though only 1 in 20 persons over 65 is in a nursing home in a given year, 1 in 4 will at some time enter one.²⁰ Chronic illness or disability may require large expenditures for medical care, personal care, or social support services. Moreover, the size of the expenditures for a given disability will vary with other contingencies, such as family situation and preferences for living conditions. The uncertainty surrounding each of these contingencies and their joint risk suggest that the rational consumer will enhance his well-being over his lifetime if he pays a modest insurance premium rather than keeping the money and

¹⁸ For a summary of these issues, see R. Morris and P. Youket, *Long-Term-Care Issues: Identifying the Problems and Potential Solutions*, in *REFORMING THE LONG-TERM-CARE SYSTEM*, eds. J.J. Callahan and S.S. Wallack (Lexington: D.C. Heath, 1981): 11-28.

¹⁹ I draw on Christine Bishop's excellent discussion in the next three paragraphs. Cf. *A Compulsory National Long-Term-Care- Insurance Program*, in *REFORMING THE LONG TERM-CARE SYSTEM*, pp. 61-94.

²⁰ E. Palmore, *Total Chance of Institutionalization Among the Aged*, *THE GERONTOLOGIST* 16:6 (December 1976): 504-507.

risking a large loss. Specifically, we might expect rational consumers to want insurance schemes that offer them benefits flexible enough to meet their real needs. They would want alternatives to nursing home institutionalization if they need lower levels of care, or some family help, or modifiable living quarters. Thus they would buy contingency claims on the joint risks of disability and other factors, such as the absence of family support or the unsuitability of living arrangements.

The connection between disability as an insurance problem and as a problem of savings becomes clear when we see, as Bishop notes, that short-term coverage faces special problems. If coverage is actuarially fair and we risk-pool by age, then high premiums will face the elderly, those most in need of the insurance and those least likely to be able to pay for it because of declining incomes. The prudent consumer, anticipating such higher premiums, would have to save, perhaps by buying an annuity to cover his later premiums. But since he does not know how long he will live, whether it's to 100 or to 66, it is hard to predict how much to save. Notice, however, that plans offering lifetime coverage with a fixed premium are equivalent to such savings: A community-rated lifetime plan has a built-in savings feature because of the distribution of needs by age.

Though these considerations suggest there should be a demand for such insurance, we find no market offering it. Bishop points to several reasons for market-failure:

(1) Uncertainty about inflation adds to the insurer's risk where real benefits and not fixed dollar amounts are involved, so private coverage would be discouraged.

(2) Administration costs are high if coverage of the population is not extensive.

(3) Some current public programs would partially undercut the market for such insurance.

(4) "Adverse selection," which means too many high-risk people buy, driving premiums up and low-risk people out, and "moral hazard," say in the form of overstating disability, are especially likely for these forms of insurance.

From these facts, Bishop concludes that private marketing of such insurance is not likely to develop and that some form of universal, compulsory insurance should be instituted, different proposals for which she considers.

Bishop's proposal for a unified national insurance scheme for long-term care, encompassing medical care, personal care, and social support services, is surely a step in the right direction. Moreover, her discussion of the scope and content of the lifetime coverage scheme is informed by prudential considerations, which I earlier suggested were necessary to undercut the issue of age-group competition. The scheme continues through time so that the young who pay higher premiums (or taxes) now

in due time will be beneficiaries of such "savings," through the similarly higher payments of later birth cohorts.

Still, there is a gap in her argument: The social obligation to provide such compulsory coverage does not follow from the fact of private market failure alone. Nor does it follow from the fact that net well-being might be greater if the public scheme were instituted, for many public schemes might enhance net well-being. We need some argument that the social good protected by such a cooperative social scheme is especially important, say because it is a social good that gives rise to claims of justice. Schemes such as the one Bishop discusses involve a significant income redistribution: Entitlements to benefits, presumably at an "adequate" level, will be subsidized for those who cannot buy them. But what determines that level? And why should those who are better off be willing to provide it? Moreover, as long as we are considering such insurance schemes from the perspective of the prudent agent who knows his full situation, we might find much reluctance on the part of some to enter community-rated schemes whose premiums involve subsidization of those with the worst risks. If I know I have several children whom I am likely to be able to prepare for lucrative careers, then I might not want to be in a risk-pool with childless people. My commitment to a community-related scheme that is not actuarially fair to me would have to be based on considerations other than prudence alone. My knowledge of particular facts about myself allows my individual interests to influence choice. Any bargains struck in the light of full knowledge then risk allowing the accidents of current age-group competition to unduly influence the arrangements governing long-term cooperative schemes. These considerations suggest that the distributive principles we need to embody in such cooperative social schemes are not likely to be derived from the prudential perspective of fully informed rational agents.

These limits of the first strategy and other issues in moral methodology that cannot be discussed here incline me to the second strategy. That is, for the design of cooperative social schemes, we need a perspective that abstracts in a reasonable way from the full-blown rational consumer used by the economist, but still permits some form of prudential reasoning about the "savings" problem for health care. At this point it is tempting to employ some version of Rawls's "veil of ignorance."²¹ Thus the prudent agents deliberating about principles to govern their cooperative scheme should know nothing of their age, family situation, health status, genetic history, socioeconomic status, or their particular conception of the good. Such a device

²¹ For an alternative strategy, cf. Allan Gibbard, *The Prospective Pareto Principle and Its Application to Questions of Equity in Access to Health Care: A Philosophical Examination*, Appendix G in this Volume.

might be defended on the grounds that the constraints are procedurally "fair": They reflect the deliberators' status as "free, equal moral agents." Of course, the agents would have to have some "thin theory of the good," like Rawls's primary social goods, or they would have nothing to be prudent about. Any justification for such a hypothetical contractor model would carry me much too far afield.²² Clearly it is not enough to suggest that the constraints on knowledge seem to be but exaggerations of the considerable uncertainty we face outside the veil in planning health, family, and economic eventualities over a lifetime. But since I am not prepared to offer such a defense, I shall have to restrict myself to a suggestion. Prudent deliberators, appropriately constrained, would seek a health care and long-term care system that protected their normal opportunity range at each stage of their lives. The notion of an age-linked opportunity range needs explanation, and I explore the merits of this suggestion in the next section.

Equal Opportunity and Health Care for the Elderly

I have suggested that meeting health care needs is of special moral importance because it enhances fair equality of opportunity; specifically, it helps guarantee individuals a fair chance to enjoy the normal opportunity range for their society. The normal opportunity range for a given society is the array of life plans reasonable persons in it are likely to construct for themselves. The range is thus relative to key features of the society—to its stage of historical development, its level of material wealth and technological development, and even to important cultural facts about it. Facts about social organization, including the conception of justice regulating its basic institutions, will of course determine how that total normal range is distributed in the population. Nevertheless, that issue of distribution aside, normal species-typical functioning provides us with one clear parameter relevant to determining what share of the normal range is open to a given individual—holding constant, for the moment, his skills and talents. Impairment of normal functioning through disease (and disability) constitutes a fundamental restriction on individual opportunity relative to that portion of the normal range his skills and talents would ordinarily have made available to him.

Of course, we also know that skills and talents can be undeveloped or misdeveloped because of social conditions (e.g., family background). So if we are interested in having

²² For a discussion of the presuppositions in such an account, cf. my *Wide Reflective Equilibrium and Theory Acceptance in Ethics*, *JOURNAL OF PHILOSOPHY* 76:5 (May 1979): 256-282; also my *Reflective Equilibrium and Archimedean Points*, *CANADIAN JOURNAL OF PHILOSOPHY* 10:1 (March 1980): 83-103.

individuals enjoy a fair share of the normal opportunity range, we will want to correct (say through education) for special disadvantages here too. Still, restoring normal functioning has a particular and limited effect on an individual's enjoyment of the normal range of opportunities. It lets him enjoy that portion of the range to which his full range of skills and talents would give him access, assuming that these too are not impaired by special social disadvantages. There is no presumption here of eliminating individual differences: These act as a baseline constraint on the degree to which individuals enjoy the normal range.²³

The notion of a normal opportunity range can be refined for its special application to our problem about distribution between age-groups. Life plans, we might note, clearly have stages that reflect important divisions in the life cycle. Without meaning to suggest a particular set of divisions as a framework, it is easy to observe that lives have phases in which different general tasks are central: nurturing and training in childhood and youth, pursuit of career and family in adult years, and the completion of life projects in later years. Of course, what is reasonable to include in a life plan for a stage of one's life reflects not only facts about one's own talents and skills, tastes, and preferences, but also depends in part on social policy and other important facts about the society. These qualifications already are present in the notion of a normal opportunity range.

The suggestion I want to explore is that prudent design of the institutions that affect us over the different stages of our lives requires reference to the notion of age-linked opportunity range. Specifically, prudent deliberation about the design of such institutions, carried out with the degree of abstraction from individual perspective appropriate to the task, would attempt to assure individuals a fair chance at enjoyment of the normal opportunity range for each life stage. With this refinement, the fair equality of opportunity account I am proposing for health care will avoid the pitfall of age bias.

Consider now the perspective of designers of a health care system who are under an appropriate veil of ignorance. It keeps them from knowing their individual health status, conception of the good, age, income, and other important facts about themselves as individuals. At the same time it lets them know important facts about the disease/age profile for their society, its technological level, and even that life span has been increasing,

²³ I believe this formulation avoids criticisms of my account raised by Allen Buchanan in his *The Right to a Decent Minimum of Health Care*. It is important to see that normal opportunity range abstracts from individual differences in what I call "effective opportunity." From the perspective of an individual with a particular conception of the good, "effective opportunity" range will be a subspace of the normal range. Cf. my *Health Care Needs*, p. 159.

largely as a result of other features of social policy. One feature of their problem emerges as critical: In choosing principles for institutions that defer the use of resources, they must assume life span is normal. Since they cannot appeal to any very special conception of the good, which might lead them to discount the importance of their projects or plans at a certain stage of their lives, they must treat these stages as of comparable importance. Here they are simply in compliance with Sidgwick's account of rationality: Each moment of life is equally valuable and must not be discounted merely because it comes at one point in our lives rather than another.

Of course, there are standard problems facing the Sidgwickian view. Even though it disallows "pure time preferences," it does not block some "impure" reasons for discounting the value of certain moments. Nevertheless, given our problem of design from behind a veil of ignorance, some special views people might hold are not available to them. Still, there are other problems. The concept of rationality itself does not determine which moments are to count as "ours." If I refuse to plan for "my" care when "I" have advanced senility, am I being imprudent? Am I being irrational if I insist that *that* senile person (if he is one) is not really *me*, and that I do not care what happens to him? I ignore these worries here.

From their perspective, prudent deliberators will not know just what their situation is, what preferences or projects they might have at a given stage of their lives. Still, they do know that they will have a conception of the good and that it will determine what is meaningful to them in their lives. But then it is especially important for them to make sure social arrangements give them a fair chance to enjoy the normal range of opportunities open to them at any stage. This protection of the range of opportunities they enjoy is doubly important because they know they may want to revise their life plans; consequently, they have a high order of interest in guaranteeing themselves the opportunity to pursue such revisions. But impairments of normal species functioning clearly restrict the portion of the normal opportunity range open to an individual at any stage of his life. Consequently, health care services should be rationed throughout a life in a way that respects the importance of age-linked opportunity ranges.

Let us consider two implications of this view for the design of health care systems, keeping in mind that these systems operate through time on all stages of one's life. The first implication is the suggestion that personal medical services have the same underlying rationale for their importance as various personal care and social support services for the disabled. Medical services are intended to preserve or restore normal functioning; in turn, normal functioning is important because of its impact on individual opportunity range. But just the same rationale makes personal care and support services for the

disabled elderly person important: They compensate for losses of normal functioning in ways that enhance individual opportunity.

A major criticism of the U.S. health care system, that it encourages premature- and over-institutionalization of the elderly, should be assessed in this light. The issue becomes not just one of costs: Is institutionalization more or less cost-effective compared with home care and social support services? Rather, the opportunity range for many disabled persons will be enhanced if they are helped to function normally outside institutions. They will have more opportunity to complete projects and pursue relationships of great importance to them, or even to modify the remaining stage of their life plans within a greater range of options. Often the issue is discussed in terms of the loss of dignity and self-respect that accompanies premature institutionalization or institutionalization at inappropriate levels of care. My suggestion here is that the underlying issue is loss of opportunity range, which obviously has its effect on autonomy, dignity, and self-respect. Viewed in this light, the British system, in which extensive home-care services exist, respects the importance of a normal opportunity range for the elderly far more than does our system.

The second implication is more controversial, and I am less sure of it. I believe that prudence would dictate giving greater emphasis to enhancing individual chances of reaching a normal life span than to extending the normal life span. It might at first seem that such a contention runs counter to the earlier appeal to Sidgwick's principle, that it is irrational to entertain pure time preferences. But I am not urging that a given moment of life for a person older than the normal life span is worth less than a comparable moment for a younger person. About that, the prudent deliberator can make no judgment. But he must acknowledge several important considerations. Assume, for the moment, that productivity and birth rate are held constant. Then, increasing life span—here beyond the normal range—must compel us to save resources at a greater rate in earlier stages. Where policies lead to greater longevity primarily because they reduce infant and childhood mortality rates, we are likely to have some increase in productivity, which may not necessitate greater rates of saving. But where the extension is due primarily to marginally extending the lives of elderly people, then we clearly are required to save at an increased rate. To the extent that such increased savings undermine the ability to protect normal function in younger age-groups, or even in the late stages of a normal span, we face an increased likelihood of not reaching a normal life span. Prudence would thus urge us to pursue a different policy. Under the conditions imposed here on institutional design, we can abstract from what might merely be thought a matter of personal taste, whether to live a longer life with fewer resources or enjoy a better chance of living a normal life span.

Consider the rationing schemes discussed earlier. Recall that Scheme A permitted no one over age 65 or 70 to get certain high-technology, high-cost services. Such rationing by age permitted the development and use of more such services for younger people. Scheme B developed fewer such services and rationed them solely by criteria involving medical suitability and lotteries. I am suggesting that prudential considerations would incline our modified prudent deliberators to choose an enhanced chance of reaching a normal life span over an increased chance of living a life slightly longer than the normal span. If this conclusion is correct about where prudential considerations incline us, then my strategy of using prudence to guide justice in distributions between age groups should lead us to think Scheme B is morally preferable. The whole point here is that the scheme works through time: Each of us, not just a particular group of people, will enjoy the increased chance of reaching a normal life span. And our gain in this regard is not made at the expense of another group, but at the expense of our reduced chance of living to a longer than normal life span.

The point brings to mind a rationing practice ascribed to the Aleuts: The elderly, or the enfeebled elderly, are sent off to die, sparing the rest of the community from the burden of sustaining them. From descriptions of the practice, the elderly quite willingly accept this fate, and it is fair that they should. They were the beneficiaries of comparable sacrifices by their parents and grandparents. If prudence demands such a harsh rationing scheme in the conditions the Aleuts face, then we are blocked from any suggestion that the practice is age-biased in a morally unacceptable way. Yet this example should remind us that such rationing schemes are prudent only under certain explicit conditions. So the prudence of selecting Scheme A over Scheme B in the preceding deliberation is quite sensitive to assumptions about the scarcity of resources and the way in which policies involve explicit trade-offs. The argument is not a general defense of all schemes for rationing by age.

It is worth noting one last implication of these considerations and this strategy for approaching the age-group distribution problem. Where prudential considerations do not decide between alternative schemes—and some might reject my argument leading to the selection of A over B—we may not be dealing with a consideration of justice at all. More generally, several schemes may appear prudent; then we have no basis in considerations of justice for distinguishing among them. Where there are honest differences about what is prudent, then we may be dealing with cases whose resolutions call for a democratic political process, not transcendent principles of justice.

Equity, Errors, and the Suitability of “Savings Institutions”. Thus far I have ignored an important question facing cooperative schemes in which saving is accomplished through a compact between birth cohorts. In such schemes, one birth

cohort transfers resources for the use of earlier birth cohorts and receives similar transfers from its successors. (We support our parents and expect our children's support in return.) How can a given cohort be assured that its benefits from the scheme will be equitable when compared to the benefits enjoyed by other cohorts? If we call the ratio of benefits received to contributions made the "replacement ratio," our problem is to determine when replacement ratios are equitable.²⁴

The problem arises because we must operate such a savings scheme under conditions of considerable uncertainty. Most importantly, there is uncertainty about population growth rates, economic growth rates, and the impact of technological change on productivity. Consequently, any such scheme must derive its stability from an underlying commitment to equity in replacement ratios enjoyed by successive birth cohorts. Errors are likely to abound, and inequities will arise, but the presumption must be that these errors will be corrected. Still this presumption in favor of correcting errors does not mean that everything is up for renegotiation all the time. The basic institution must be stable.

Clearly we need some theory about what equity involves here. I think this problem of equitable treatment between birth cohorts resembles the problem of a just savings rate between present and future generations, but I cannot say more about the connection here.²⁵ Instead, I shall rely on the point just made about the higher-order interest parties have in assuring the stability of the savings institution. Stability requires a belief in equity. If one cohort seeks terms too much in its favor, say when it is young, it will very likely pay the price when it is old; similarly, if it seeks too much when it is old, it will risk rebellion from the young. My guess is that there is a tendency to view equity as requiring approximate equality in replacement ratios. In any case, I shall make such an assumption, primarily for the sake of illustrating a slightly different point.

Suppose, then, that "mature" savings schemes, those in which beneficiaries have been long-time contributors, should treat different birth cohorts equally. They should aim for equal replacement ratios. In the steady state condition, where there is no economic growth and no population increase, the assumption is unproblematic. In favorable conditions of positive economic growth and increasing population, we can in fact do better in the following sense: Benefits can steadily increase, even if rates of contribution do not. Of course, equity considerations between cohorts might incline us to temper this "chain letter" effect: If we could project the economic and demo-

²⁴ Cf. D.O. Parsons and D.R. Munro, *Intergenerational Transfers in Social Security*, in *THE CRISIS IN SOCIAL SECURITY: PROBLEMS AND PROSPECTS*, ed. M. Boskin, pp. 65-86.

²⁵ Cf. n. 15

graphic trends, we might raise the replacement ratios of earlier cohorts somewhat to offset the anticipated increasing rates of later cohorts. Unfortunately, in our Social Security and health care contexts, we now face the opposite conditions—declining birth rates and poor economic growth. What this means, in the Social Security system, for example, is that the current 3:1 ratio of contributors to beneficiaries will decline to about 2:1 by 2030 (in the immature system of the 1950s, ratios were even more favorable). To maintain current benefit levels, contributors have to be taxed at tremendously high rates. (The same point applies to health care “savings” schemes.) What is worse, much of our recent planning, including the major benefit increases of 1972, seemed to ignore these shifts. To have planned for equity in replacement ratios, many critics argue, would have required (1) taxing earlier generations at a yet higher rate than they were taxed, (2) stunning increases in real wages through rapid economic growth, (3) reducing benefits substantially in the interim, or (4) some combination of these steps.

One problem is that the presumption in favor of equitable treatment between cohorts encounters strong resistance in the political arena. Some cohorts are in a better position to protect their interests than others, undermining long-term stability of the scheme. A second problem is that not everyone believes or understands the problem, and there is often reason to think some factors are exaggerated, perhaps for ideological reasons. Thus many people point with alarm to the shifting ratios of contributors to beneficiaries. But there is a countervailing point: The total ratio of employed to non-employed, lumping retirees together with children, is not changing in such an alarming way. The ratio of total non-labor to labor was higher in 1975 than it will be for any year through 2040.²⁶ The implication is that the smaller number of children will require fewer resources, which can be diverted for use by the then elderly baby-boom cohort. What follows, then, is that we must not look too much at one distributive institution in isolation from others.

Nevertheless, the general point remains. We operate an income or savings scheme in a non-ideal context. It will always encounter various sorts of interstitial equity considerations that are generated by both great uncertainty and political expediency.²⁷ A good example is the tremendous replacement-ratio advantage offered the early entrants into our Social Security system. Attempting to lower that ratio might have undermined political support for the Social Security system as a whole. Similarly, in the United States, no fund was ever generated that was significant enough to cushion the effects of our current

²⁶ J. Schultz, *ECONOMICS OF AGING*, 2nd ed. (Belmont, CA: Wadsworth, 1980), p. 11.

²⁷ Brian Barry, *POLITICAL ARGUMENT* (London: Routledge & Kegan Paul, 1965), Ch. 9.

decline in real wages and declining population growth rate. Politicians were afraid to raise tax rates without pairing the increases with benefit increases. More interesting details of this history are available and constitute an important case study of the contrast between ideal and non-ideal contexts.²⁸

It is interesting to note that health care savings schemes face comparable—or even more serious—problems of birth cohort equity. First, as in the case of income-support schemes, there will be a bias in favor of early entrants. Such a bias is hard to avoid in immature schemes. But there also is an opposite bias in the case of health care. Consider a scheme in which some form of age rationing of new technology is involved. Our Scheme A will do as an example. An elderly person might complain about A by saying it is not really fair to his cohort, his cohort never had the benefit of increasing its chances of reaching a normal life span because the technology (say, dialysis) now being denied it was also not available in its youth.

Two points might be made in response to this complaint. First, it might be argued that each birth cohort is treated equally in the following way. At some point in life, each cohort will be denied the best available life-extending technologies, but at all other points in life it will have a better chance of receiving them. To be sure, the particular technology (dialysis) it is denied may not be the very one it had a better chance of receiving, but there is a fairness in the exchange. Still, if technology improves very rapidly, then the bargain is not quite as favorable from a prudential perspective as it might have seemed when we ignored the fact or rate of technological advance. A second point is more general: Some such changes, e.g., in technology, are at least as difficult to project as the other factors that lead to error (replacement-ratio differences) in saving schemes. Indeed, it seems in general the case that we might be even more prone to error in the health care setting than in the income-support setting. In such a context, given the overriding importance of stability in such schemes, there must be considerable tolerance for error.

Some Qualifications

I fear it is easy to misconstrue, at least to misapply, my argument. It does not, in general, sanction rationing by age. Such justification is possibly only under very special circumstances. For example, it should not be taken as a hasty endorsement of age rationing as a convenient cost-constraining device in the context of current debates. Part of the temptation to misconstrue the force of my argument comes from failing to

²⁸ Cf. Martha Derthick's excellent discussion, *POLICY MAKING FOR SOCIAL SECURITY* (Washington D.C.: Brookings Institutions, 1979).

recognize the difference between ideal and non-ideal moral contexts.

It is important to see that many of the problems facing large numbers of the elderly in our society are consequences not of age bias but of other inequalities—and, I would argue, injustices. The worst-off among the elderly are usually the same people who were worst-off in earlier stages of their lives. Problems with social and individual savings schemes may exacerbate their plight, but their ultimate situation is largely determined by their earlier position in society. This is not, of course, to say they are getting what they deserve. It is to raise the more basic question about the justice of the underlying distributive institutions. In the context of such injustice, it is just blaming the victim to talk about the “inadequacy” or even the “imprudence” of “their” savings. No one could reasonably be expected to save prudently for old age from such inadequate income and wealth shares in their working years. Of course, we can rectify or adjust for underlying inequities by income and health care support in the later years, which we to some extent do. But this adjustment should not primarily be seen as an issue of justice between age-groups; it is really a more basic issue of distributive justice that forces the correction.

Nevertheless, I have been claiming that there is a distinct problem of distributive justice here. The residual problem is to select principles of distributive justice that will govern the basic institutions responsible for distributing social goods through the various stages of life. My proposal has been that a form of prudential reasoning should guide the design of such institutions. From the perspective of such institutions, goods are distributed through the stages of life, not between different persons in distinct age-groups. In the case of health care institutions, justice requires we allocate health care in a manner that assures individuals a fair chance at enjoying the normal opportunity range, and prudence suggests that it is equally important to protect individual opportunity ranges for each stage of life. Under certain assumptions, prudence would urge some forms of rationing by age. Similarly, prudence might suggest that some forms of non-medical services that meet the health care needs of the elderly are more important than certain medical services, because they better protect the normal opportunity range for that stage of life. But suggesting that prudence is our guide to the design of “savings institutions” does not, of course, mean that these matters of design are not matters of justice. Here prudence guides justice; it does not prevent us from talking about it.

In proposing that we use prudential considerations to determine the justice of distributions between age-groups, I take for granted a background involving other just institutions. It is in this sense that I have been concerned with a problem in what

is known as "ideal" moral theory: We are looking at principles and institutions operating in a society that is, in general, just. Remarks about the permissibility of rationing by age must thus be taken in this context. If the basic institutions of a given society do not comply with acceptable principles of distributive justice, then rationing by age could make things even worse. Indeed, prudential considerations that might endorse rationing by age depend on what sort of resource scarcity exists. Moreover, the source of the scarcity is important. If the scarcity is the result of unjust arrangements operating elsewhere in the system, then the argument from prudence may well be undermined.

My worries here are part of a more general problem. In another context, I have argued that the moral philosopher considering issues of public policy must take into account both the *framework* from the problem and the *context of compliance*.²⁹ A framework is determined by how much of the basic political, social, and economic institutions we take to be fixed and how much we allow to be revised in the social system under question. The more major changes of fundamental institutions we allow, the more basic the framework. The context of compliance is the degree to which the problem arises in a society that complies with acceptable principles of justice for its basic institutions. "Ideal" theory is full-compliance theory.

Philosophers (myself included) have generally concentrated on basic frameworks and have for the most part concerned themselves with ideal theory. Yet public policy makers operate in less basic frameworks and, I believe, in contexts far from ideal. Too little philosophical attention has been paid to the problem of making points developed for basic frameworks and ideal theory relevant to the public policy maker. Philosophical vision is fine, but the philosopher must focus his vision on the problem raised by the policy maker. Unfortunately, the myopic bureaucrat, whose vision has adapted to ensure his survival in non-basic frameworks, may not see any relevance in philosophical vision. What is at once a philosophical problem, of connecting ideal and non-ideal contexts, is also a political problem: The philosopher must not let himself become myopic as the price of seeing things in the relevant light.

²⁹ Cf. my *Conflicting Objectives and the Priorities Problem*, in *INCOME SUPPORT: CONCEPTION AND POLICY ISSUES*, eds. P.G. Brown, C. Johnson, and P. Vernier (Totowa, NJ: Rowman and Littlefield, 1981).

Health Care and the “Deserving Poor”

George Sher, Ph.D.*

The idea that some poor persons deserve to be helped while others do not has long been influential in this country. In the nineteenth century, this idea was responsible for a sharp separation in the treatment afforded to different classes of the poor. The blameworthy poor—the “paupers”—were relegated to poorhouses and subjected to onerous conditions in order to receive relief, while the blind, the deaf-mute, and other blameless classes of the poor were helped in much less humiliating ways. A similar distinction underlay the structure of categories of relief recipients established by the comprehensive Social Security Act of 1935; and a continuation of it has motivated various attempts to revise the welfare system by redrawing its boundaries and making work a condition of aid.¹ Most recently, the idea that some poor persons are more deserving than others has resurfaced in discussions of subsidized medical care.

Given its persistence and intuitive appeal, the distinction between the deserving and undeserving poor is obviously of considerable importance. However, despite its centrality, it has received little philosophical attention. In the present paper, I will try to remedy this lack. Because the distinction between the deserving and undeserving poor is by no means clear, I will begin by trying to clarify it. In the first section I will identify various notions of desert that the distinction has embodied. Next I will sketch a way of integrating some of these elements to yield a coherent concept of the deserving poor. Finally I will connect the earlier discussion with some special problems raised by health care.

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¹ For more details, see Joel F. Handler, *REFORMING THE POOR* (New York: Basic Books, 1972); and Robert T. Stevens and Rosemary Stevens, *WELFARE MEDICINE IN AMERICA* (New York: Free Press, 1974).

Moral Views of Desert

The thought that animates the term “deserving poor” is that there are moral grounds for helping some poor people but not others. But what conception of morality is involved, and what role does desert play in it? There are, it seems, at least five elements to consider.

Past Actions. The root idea of desert is that how well or badly a person fares should be determined by his own actions. The virtuous deserve to be rewarded, the wicked to be punished, the hard-working to prosper, and the improvident and lazy to do without. Given this basic conception, one way of connecting poverty with desert is immediately obvious. In at least some cases, a person’s poverty is due to his profligacy, improvidence, or laziness—due to advantages squandered and opportunities not taken. When this is so, the person’s poverty may be said to be deserved because of his previous behavior. More controversially, it may also be held that poverty is deserved because of other behavior—for example, behavior that is considered immoral. Sexual promiscuity has often been mentioned in this connection.

Present Actions. We have just seen that a poor person may be said to deserve his impoverished status because of his past behavior. But one may also connect poverty with desert by invoking someone’s present behavior. Whatever its history, a person’s poverty may be currently avoidable. There may be work he could do that would provide him with a decent income. If a poor person rejects such work or makes only a half-hearted attempt to do it, then he may again be said to deserve (the continuation of) his current status. Although the first statement and this one disagree about which actions are relevant, they agree that one may deserve poverty because of one’s actual behavior.

Projected Actions. Just as a poor person’s past and present actions have been thought relevant to what he deserves, so too have his projected future actions. In the nineteenth century it was commonly believed that easy access to relief corrupted the poor. It was said to reduce their incentive and make them unwilling to work. Similar suggestions have been made in recent years about welfare. If someone’s incentive to work will be reduced by the availability of aid, and if the incentive to work is a good thing, then there is a reason (though not necessarily a conclusive reason) to curtail or deny aid to that person. We may, if we like, express this by saying that the person whose incentive will be reduced deserves to retain his impoverished status. However, we must be careful here. When “deserve” is used in this way, it loses its original connection with what one has done or is doing and becomes entirely future-oriented. In

this sense a person may hitherto have been industrious and yet now be deserving of poverty. Given its lack of connection with the root notion, this use of "deserve" is misleading at best.

Uncontrollable Incapacities. Thus far we have considered several interpretations of the contention that some poor persons deserve their current status, and therefore have no right to be helped. But can we also make sense of the contention that others deserve *not* to be poor, and thus should be provided with relief? Although this contention is appealing, it raises conceptual difficulties. As we have seen, the root idea of desert is that how well a person fares should depend on his own actions. However, what is striking about the deserving poor is precisely how many of them have done nothing that could plausibly render them deserving. The category does include many who remain poor despite meritorious efforts to support themselves; but it also includes many who are simply incapable of such efforts. The infant children of indigent parents have done nothing at all, and yet they are plainly among the deserving poor if anyone is. Thus, the claim that persons in this category deserve to be helped cannot be taken at face value. There is, however, a less direct sense in which the claim is true. If the young, the blind, and the disabled have not acted in ways that render them deserving, the reason for this often lies in factors beyond their control. Because of this, their inability to support themselves, and so too their poverty, is often itself undeserved. Thus, even though they have done nothing to deserve aid, they may still be said to deserve it in the secondary sense of not deserving the incapacities that have prevented them from becoming deserving in the primary sense.

Social Obligations. By itself, this is not sufficient to establish that the "deserving poor" should receive aid. Even if the persons in this category do not deserve to be poor, and even if they do not deserve the incapacities that prevent them from deserving benefits in the primary sense, the fact remains that many of them are not deserving of benefits in the primary sense. Many of them have done nothing to deserve either poverty or prosperity, and so desert establishes no presumption either for or against providing them with aid. If they have a claim to be aided, that claim must be defended on some other basis. Although its details are controversial, the contention that the claims of the poor do have some other basis seems quite plausible. That basis might consist of either (1) a principle of just distribution that establishes a social minimum or (2) a right to be provided for when one cannot provide for oneself. However, it would strain usage to say that our obligation to provide aid for the young, blind, or disabled stems from their desert. Strictly speaking, many of the "deserving poor" are not deserving at all.

An Integrated View of Desert

My aim so far has been to distinguish a number of possible interpretations of the contention that some poor persons deserve to be helped while others do not. As we have seen, that contention can appeal to past actions, present actions, future actions, uncontrollable incapacities, or obligations arising from entitlement or justice. But having come this far, we can go further. Instead of taking these appeals as competing interpretations of the distinction to be explicated, we may incorporate them into a single and coherent account of it. I shall first propose and then discuss such an account.

I propose that the distinction between the deserving and undeserving poor operates in several stages. At the first stage, a person's claims to relief from poverty are grounded in some appropriate principle of justice or in some entitlement—not in desert. However, although desert is not the basis for claims to aid, it may qualify those claims in two ways. First, if desert is morally significant at all, then claims to aid that would otherwise be established by justice or entitlements may be limited or canceled by the fact that one's poverty is the result of his own doing, and hence is deserved. Second, any contention that a person's poverty is deserved is rebutted by the fact that the person is poor because of an ability to work that is itself undeserved. Because the fact that an incapacity is undeserved plays the latter role, this view preserves the intuition that desert helps to determine who *should* be aided as well as who should not. However, because the fact that one's incapacities are undeserved serves only to rebut the contention that one's poverty is deserved, desert does not create claims to aid, but merely preserves them.

Although I shall not argue the point, I think this way of looking at things does capture what most people have had in mind when distinguishing the deserving from the undeserving poor.² However, to say that we have captured the distinction's structure is not to say that the distinction can be defended. A

² I can envision one possible reason for rejecting the proposed interpretation. It is sometimes held that the obligation to provide relief to the poor is not a matter of rights or justice, but only a special instance of the general obligation to be charitable. Because no particular recipient of charity has any special claim to be aided, this suggestion makes it impossible to say that someone's claim to be aided may be qualified by what he deserves. Hence, if one accepts this position, one will have to defend the practice of not helping the undeserving poor in some other way. One possibility is to appeal exclusively to the consequences of dispensing aid selectively—to say that doing so will increase or sustain work incentives. Another is simply to say that the practice needs no defense—that those who dispense charity have a right to decide who gets it and who does not.

fortiori, nor is it to say that persons with particular characteristics should or should not be helped. To further clarify these matters, we must examine each of the distinction's elements in more detail.

Because the distinction begins by postulating a societal obligation to provide relief from poverty, the natural first question concerns the grounding of this obligation. Exactly how is the underlying conception of justice or entitlement to be defended? Because there is fairly broad agreement that some such conception is defensible, I shall not pursue this question here. Instead, I shall move directly to the further question of whether the obligation to provide aid really can be said to fail when someone deserves his impoverished status. Given the moral significance that we attach to desert, this at first seems reasonable enough. However, one might object that desert is not generally considered so weighty. When persons have rights to things that they do not deserve, we generally consider it wrong to treat them as they deserve. Thus, it may seem implausible to suppose that our obligation to provide aid could be canceled by the fact that someone's poverty is deserved.

If the distinction between the deserving and undeserving poor rested on the assumption that desert of poverty overrides one's right to be helped, then this objection would tell heavily against it. However, in its most promising form the distinction involves no such assumption. Instead of assuming that desert of poverty overrides one's right to be helped, the distinction need only assume that the right to be helped does not extend to those who have been improvident or are currently capable of supporting themselves. It need only assume that considerations of desert are internal to rights or their justification—that such considerations determine the conditions under which someone does or does not have a right to be treated in a certain way. In this interpretation the fact that rights generally prevail when they conflict with desert is simply irrelevant. Of course, it is one thing to say that desert determines the boundaries of the right to be aided and another thing to prove this. However, it is widely acknowledged that desert of punishment places limits on the right not to be harmed; and it seems no less plausible to say that other sorts of desert may limit the right to be helped. Because of this, and because analogous considerations apply *mutatis mutandis* to the relation between desert and justice, the view that there is no obligation to aid those whose poverty is deserved may indeed be defensible.

Assuming it is, what can be said about the conditions under which a person's poverty is deserved? Shall we say that someone deserves poverty when he has been improvident or lazy in the past? When he is currently unwilling to support himself? When he has pursued an immoral course of behavior? When his initiative would be undermined by aid? And which-

ever set of answers we accept, how poor does one deserve to be when he satisfies the relevant conditions, and how long does his desert last? Without principled answers to these questions, the distinction between the deserving and the undeserving poor will be empty. It will therefore be in danger of degenerating into a rationalization for meanness or simple prejudice.

To clarify the conditions under which poverty is properly said to be deserved, we must look more closely at the notion of desert itself. In the current context, the most important fact about this notion is its intimate connection with responsibility and freedom of choice. We strongly believe that people should be treated as though they are capable of shaping their own lives, and that whenever possible they should be given the opportunity to do this within a just social framework. But to treat a person as capable of shaping his own life is in part to allow him to live out the life he has already chosen for himself. It is to permit him to live with the expected consequences of his choices. Our commitment to free choice therefore implies that, when a person's choices have been structured by a just framework that violates no one's rights, the person should generally be left to enjoy or suffer the predictable consequences of his actions. But to say that someone should live with a certain state of affairs because it was the predictable consequence of his previous choices is just to say that he should live with that state of affairs because he deserves to. Thus, our commitment to desert is revealed as the retrospective aspect of our commitment to free choice.³

These remarks merely hint at a full account of desert.⁴ As they stand, they ignore far more than they explain.⁵ Even so, they suggest answers to some of our questions about when poverty is and is not deserved. First, they clearly confirm the

³ Taken as a whole, the account I have proposed may appear circular. I suggested earlier that what a person deserves can affect what he is entitled to or what justice demands that he receive; while I am now suggesting that considerations of entitlement or justice set the stage for the acquisition of desert. But I believe this circularity is benign. We may view desert and entitlement, or desert and justice, as two equally fundamental notions that qualify one another's application, and that work in tandem to determine the proper structuring of the social order. I owe this way of putting the matter to Arthur Kuflik.

⁴ For some discussion along similar lines, see James Rachels, *What People Deserve*, in John Arthur and William Shaw, eds., *JUSTICE AND ECONOMIC DISTRIBUTION* (Englewood Cliffs: Prentice-Hall, 1978), pp. 150-63.

⁵ Among the questions left unresolved are: What is the connection between this sort of desert and desert of punishment? When, if ever, does someone deserve an outcome that he rightly foresaw as possible but unlikely? And when, if ever, does someone deserve an expected outcome that is produced by what someone else does in response to his behavior?

intuition that poverty cannot be deserved for future actions. If desert is created by someone's choices, then it can only arise after one has actually made those choices.⁶ Second, the above remarks suggest that a poor person generally does not deserve his impoverished status merely because he has lived promiscuously or in other ways that are considered immoral. Whatever the predictable consequences of such behavior might be, the inability to support oneself is not generally among them.⁷ Third, these remarks suggest that when one does deserve poverty, both the appropriate level of well-being and the length of time it is deserved are determined by expectations that were reasonable in light of the behavior that created the desert. If someone's past actions could not reasonably have been expected to render him totally or permanently unemployable, then he is hardly deserving of this status now. And, fourth, these comments explain why someone who is currently unwilling to work seems more deserving of his impoverished status than one who was lazy or imprudent in the past. In the proposed account, this follows immediately from the fact that it is easier to foresee the direct than the long-range consequences of one's acts.

Thus far we have considered and rejected two challenges to the distinction between the deserving and the undeserving poor. We have seen that considerations of desert may indeed place limits on claims to aid, and that a principled account of when one's impoverished status is deserved may well be forthcoming. But the distinction may be challenged in at least one further way. We noted earlier that a person's impoverished status is not deserved when it stems from an undeserved incapacity. However, according to many social scientists, the basic causes of poverty are precisely those conditions that render the poor incapable of improving their lot. In particular, poverty has been attributed both to an economic system that cannot or will not absorb the energies of the unskilled, and to a "culture of poverty" that perpetuates poor work habits, low self-esteem, and other psychological traits that work against independence and success. For easy reference, I shall call the first suggestion the *economic* explanation of poverty and the second the *socio-psychological* explanation. If we accept either suggestion, we may be tempted to say that the basic causes of poverty are

⁶ Of course, even if a person's projected responses to aid do not affect what he deserves, they may still affect what he should get. If reduced incentives will be among the consequences of aid, they must count against it as heavily as any other negative consequences of similar importance. I shall not, however, attempt to specify how heavily they should count.

⁷ Even when someone's sexual activity has produced more children than can be supported, the action whose foreseeable consequences are relevant is generally not the sexual activity itself, but rather the associated neglect of contraceptive precautions.

hopelessly beyond the control of the poor. Hence, we may be tempted to conclude that most or all the poor fall into the deserving category.⁸

It seems to me, however, that this conclusion follows from neither the economic nor the sociopsychological explanation of poverty. To see why not, let us first consider the economic explanation. To simplify discussion we may simply grant that there are many more unskilled people than suitable jobs, and that considerable imbalance would persist even if every poor person made all reasonable efforts to improve his skills. Despite appearances, these concessions do not imply that everyone who is poor has been made so by factors beyond his control. First, even if some who lack the opportunity to develop skills will inevitably end up poor, it hardly follows that everyone who ends up poor has lacked the opportunity to develop skills. Some of the poor are poor for other reasons. Moreover, even among those who have lacked the opportunity to develop skills, not all poverty is undeserved. In particular, we may still attribute desert of poverty to at least some persons who have not tried to support themselves. Of course, we will not be able to attribute desert of poverty to those who were deterred from trying to be self-sufficient by the reasonable belief that such efforts would not succeed. However, the reasonableness of this belief is not simply a function of the ratio of potential workers to available jobs. Even if each unskilled person's prospect of adequate employment would be poor if every other unskilled person were seeking employment, each unskilled person may have much better prospects under conditions in which many unskilled persons are not seeking employment.⁹ And, of course, even those who have not deserved their poverty so far may come to deserve it if they decline a job that is offered to them.

Confronted with these difficulties, those who contend that all the poor are deserving may retreat to the sociopsychological approach to poverty. They may argue that if poverty is not caused by external factors, it must be caused by some internal impediment to self-sufficiency. If people do not try to support themselves, these impediments may include feelings of worthlessness that prevent them from taking advantage of opportunities, as well as habits that place no premium on punctuality and perseverance. But here again, questions arise. If this interpretation is to succeed, it must be true that the poor are uni-

⁸ For hints of the claim that all the poor are deserving because poverty is inevitable within our economic system, see Handler, *REFORMING THE POOR*, pp. 16, 49, 53, 56-57, 137-54, and especially 139-41.

⁹ This suggestion—that someone may deserve his impoverished status when both he and others are not trying to find employment, but may not deserve it when he alone is not trying—is similar in form to the common utilitarian claim that whether one person's action maximizes utility may depend on how many others are performing similar actions.

formly unable to resist their feelings of inadequacy or to change their habits. But is this so because all actions are beyond human control or because of some special facts about the poor? If the former, then the appeal will be to a conception of freedom that rules out desert from the outset¹⁰—a conception that is easier to defend in the abstract than to sustain in practice.¹¹ If the latter, then the special features of the poor that render them (alone) incapable of controlling their behavior must be explicated. It is conceivable that some such explication might be grounded in the fact that it is generally irrational to refuse to support oneself. However, appeals to irrationality in such contexts raise notorious difficulties. Pending resolution of these, the more plausible view appears to be that the poor act with the same diversity of motives, and have the same range of control over their propensities and habits, as others. At most, the proportion of those who lack control may be greater among the poor. However, to say this is merely to say that while psychopathology and insuperable habit may render some poor persons undeserving of poverty and may diminish responsibility and desert in others, they do not have either effect across the board. Psychological considerations may indeed alter some judgments about who is deserving, but they hardly invalidate the distinction between the deserving and the undeserving poor.

Effects of Desert on Health Care

Let us end by turning to the issue of health care. We have seen that it is plausible to distinguish between the deserving and the undeserving poor—between those whose claims to be helped are and are not canceled by the fact that their poverty is deserved. But how, exactly, does this distinction bear on medical care? Do the deserving poor ever have claims to such care in addition to food, clothing, and shelter? If they do, how widespread are these claims compared with others? And whatever the extent of the claims, what if anything does our explication imply about the ways in which they should be satisfied?

The first question, whether the deserving poor ever have claims to medical care, need not detain us long. Any argument for providing the poor with clothing, food, and shelter must rest on the obvious facts that minimal levels of these things are

¹⁰ For remarks suggesting that desert should play no role at all in determining how goods should be distributed, see John Rawls, *A THEORY OF JUSTICE* (Cambridge, Mass.: Harvard University Press, 1971), pp. 15, 75-76, 104, 310-15, and *passim*. For critical discussion, see George Sher, *Effort, Ability and Personal Desert*, *PHILOSOPHY AND PUBLIC AFFAIRS*, 8, 4 (Summer 1979), pp. 361-76.

¹¹ For a discussion that shows just how hard it would be to abandon altogether the notions of freedom and desert, see P. F. Strawson's splendid essay *Freedom and Resentment*, in P. F. Strawson, ed., *STUDIES IN THE PHILOSOPHY OF THOUGHT AND ACTION* (London: Oxford, 1968), pp. 71-96.

necessary for survival, and that somewhat higher levels are required to preserve what is valuable in life. But precisely the same is true of medical care. Many illnesses are life-threatening, and many others can make life so unpleasant as to greatly reduce its value. In addition, a reasonable degree of health is needed if one is to take advantage of life's opportunities as they arise. In view of this, the case for saying that the poor have claims to medical care seems just as strong as the case for saying that they have claims to life's other necessities. The only real question is whether such claims are more or less likely than others to be defeated by past actions or omissions.

In some contexts, claims to medical care seem more likely than others to be defeated by past behavior. Unlike other needs, many medical needs are themselves the foreseeable and avoidable consequences of people's actions. People who smoke, drink, overeat, and drive recklessly are apt to need medical care that most others do not. In many instances, the condition requiring that care is predictable and avoidable enough to be called deserved. But if a right to be provided with what one needs but cannot afford is canceled when one's inability to afford it is deserved, then that right may surely also be canceled when the conditions creating the need are deserved. Thus, medical needs created by such behavior may not create valid claims to aid.¹²

If this is so, then even those whose best efforts would not have allowed them to afford complete medical care will not automatically be deserving of all the care they need but cannot afford. However, even so, such individuals are apt to remain deserving of much of what they need. As long as one's medical needs do not arise from easily avoidable behavior, the claims to aid that they generate are no more likely to be canceled by desert than the claims arising from other needs. Indeed, it seems if anything that claims to be provided with medical care are less likely than others to be canceled; for the inability to purchase medical care seems less likely to be deserved than inability to meet other expenses. One reason for this is simply that health care often costs much more than food, clothing, or shelter. Given its higher cost, it is less likely to fall within the budgetary reach of the poor. In addition, because many illnesses cannot be foreseen, the inability to meet medical needs is less often a predictable consequence of one's actions than the inability to pay for food or shelter. Of course, where suitable medical insurance is available, this unpredictability can be eliminated. However, given the cost of comprehensive coverage, insisting on the purchase of coverage will hardly decrease the

¹² For a similar argument with respect to the claim that the poor are entitled to be provided with abortions, see George Sher, *Subsidized Abortion: Moral Rights and Moral Compromise*, *PHILOSOPHY AND PUBLIC AFFAIRS*, 10, 4 (Fall 1981), pp. 361-72.

number of people who cannot afford adequate care despite their best efforts.

Given these considerations, it is tempting to conclude that more of the poor deserve at least some medical care than deserve food, clothing, or shelter. But on closer inspection, this conclusion does not follow. When someone's best efforts would enable him to afford some but not all of what he needs, there is no reason to single out medical care as the sole necessity that he is undeservedly unable to afford. If a person needs food, clothing, shelter, and medical care, but can only afford to purchase three of these items, then there is no more reason to say that he should be provided with medical care because he cannot afford it after paying for food, clothing, and shelter, than there is to say that he should be provided with food because he cannot afford it after paying for medical care, clothing, and shelter. Properly speaking, our argument does not license either of these conclusions. Instead, it suggests only that each deserving, impoverished individual should be provided with whatever proportion of his overall needs he cannot meet on his own. If there are reasons to treat health care differently from other necessities, they have yet to be seen.

According to many, these reasons are close at hand. Medical care is unlike other necessities both in its rapidly rising cost and in the need for much attention, information, and foresight in making decisions about medical care. If the poor are left to their own devices, not all of them will acquire the needed information or exercise the needed foresight. Partly because of this, the current Medicaid program strictly specifies the services that will be paid for, and offers recipients little choice in the benefits they will receive. However, it is often objected that the resulting system is both paternalistic and wasteful—that by allowing the poor to choose among alternative delivery systems, we both give them greater freedom and promote the sort of competition that reduces costs. Thus, some have advocated a system of vouchers applicable to various medical insurance programs, allowing recipients either to pocket unspent funds or to apply them to further services.¹³ Moreover, a recipient's choice would be maximized by a simple cash stipend sufficient to meet his health-care (and other) needs. What light does the distinction between the deserving and the undeserving poor shed on the moral dimension of the debate over these alternatives?

¹³ A proposal of the latter sort is developed in Alain Enthoven, *HEALTH PLAN: THE ONLY PRACTICAL SOLUTION TO THE SOARING COST OF MEDICAL CARE* (Reading, Mass.: Addison-Wesley, 1980). For two opposing perspectives on voucher plans, see John D. Arras, *Health Care Vouchers and the Rhetoric of Equity*, *THE HASTINGS CENTER REPORT*, 11, 4 (August 1981), pp. 29-39; and Loren Lomasky, *The Small but Crucial Role of Health Care Vouchers*, *THE HASTINGS CENTER REPORT*, 11, 4 (August 1981), pp. 40-42.

The connection is a complicated one. On the one hand, anyone who accepts the distinction must attach a high value to freedom of choice. To acknowledge the moral force of desert is ipso facto to accept the ideal of respect for freedom that underlies it. Thus, the distinction tells not only against egalitarian arguments for providing medical care without considering past choices, but also against broad-gauged paternalistic arguments for restricting future choices about such care. Nor, having accepted the distinction, need we fear that society will acquire a new obligation to provide aid whenever someone uses his aid foolishly or diverts it to purchase luxury items. If a responsible person acts in this way, then he simply becomes undeserving of the necessities he cannot afford, and so loses his claim to be provided with them. However, on the other hand, we must also recall that a poor person may qualify as deserving either because he has lacked the opportunity to satisfy his needs or because he has been prevented from utilizing his opportunities by some condition that is itself undeserved. I argued above that not all persons who neglect their opportunities are prevented from taking advantage of them by undeserved conditions. Even so, it appears that some of the poor are deserving precisely because they cannot manage their own lives. Where such individuals are concerned, the freedom afforded by vouchers or unrestricted stipends would result in wasteful decisions and loss of care. Hence, even those who accept our distinction need not be opposed to all restrictions on choice of care. For some of the deserving poor, paternalism in allocating medical care may be the only answer.

Given all of this, we cannot bring our distinction to bear upon any system of vouchers or stipends without first knowing more about the composition of the group of deserving poor. If most members of this group are capable of rational choice, and if most misuses of choice would involve the sort of carelessness that renders one undeserving, then our commitment to freedom will incline us to favor a system of vouchers or stipends, other things equal. However, if many of the poor are deserving precisely because they cannot take advantage of opportunities, and if many misuses of choice would be the result of this incapacity, then the fact that many of the deserving poor would not receive adequate care in exchange for their vouchers or stipends is an argument against using them. In the likely event that the deserving poor are persons of both types, we cannot invoke our distinction until we establish priorities among its elements. In that case, we cannot evaluate any voucher or stipend system until we decide how to weigh potential gains in freedom for those who are able to run their own lives against potential losses in care for those who are not.¹⁴

¹⁴ Among the persons who stand to lose the care to which they are entitled are not only adults who are incapable of rational choice, but also the dependent children of all those who misuse their aid.

A full treatment of this decision is obviously beyond our scope. However, to end, we may notice two considerations that seem fully compatible with the framework of desert but may diminish the weight we attach to potential gains in freedom. Of these considerations, the first is our common desire to temper justice with mercy—to provide aid to persons in desperate straits regardless of what they deserve. Even if society is not obligated to provide health care for those who have squandered the opportunity to acquire it, it seems inhumane, and indeed indecent, to let someone suffer or die for lack of easily available care. Because we are reluctant to do this, but are also reluctant to pay for the same services twice, we feel a natural inclination to dispense aid in ways that prevent it from being misused. In addition (and somewhat paradoxically), we may also wish to restrict the use of aid because we know that that aid is less than fully sufficient. When a person cannot purchase everything he needs, the harshness of his choices may interfere with his ability to allocate his resources properly. Although it is irrational to ignore all questions of future security, we may simply expect too much when we ask someone to scrimp on food and clothing to purchase medical insurance he may never use. Of course, the best way to protect the deserving poor from such harsh choices is simply to provide them with all of what they need. However, when political or economic constraints make this impossible, even those who accept the ideal of freedom may endorse some restrictions on choice to correct for unavoidable distortions of judgment.¹⁵

¹⁵ This paper has been improved by the helpful suggestions of Hilary Kornblith, Arthur Kuflik, and Alan Wertheimer.

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